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HEALTH CARE REFORM (Part 7)

HEARINGS BEFORE THE SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT OF THE COMMITTEE ON ENERGY AND COMMERCE HOUSE OF REPRESENTATIVES ONE HUNDRED THIRD CONGRESS SECOND SESSION

JANUARY 24, 1994—IMPACT ON SPECIAL POPULATIONS
JANUARY 25, 1994—ESSENTIAL PROVIDERS, ACADEMIC HEALTH
CENTERS, HEALTH WORKFORCE, AND GEOGRAPHIC ISSUES

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HEALTH CARE REFORM Impact on Special Populations

MONDAY, JANUARY 24, 1994

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:10 a.m., in room 2123, Rayburn House Office Building, Hon. Henry A. Waxman (chairman) presiding.

Mr. WAXMAN. Good morning. The subcommittee will please come to order.

Today the subcommittee resumes its hearings on President Clinton's Health Security Act. The hearings that we will hold over the next 3 weeks will build upon the 14 hearings we held last fall and are designed to prepare the members for markup of the President's bill at the end of the February.

The title of today's hearing is "The Impact of the Clinton Plan on Special Populations," But the hearing is really about the diversity of America. The diversity of this country is its strength. But America's diversity also means that in designing health care reform, we need to address a truly daunting range of special circumstances that different groups of Americans face.

For the first time in 12 years, a President has proposed universal coverage of comprehensive benefits, but President Clinton recognizes that issuing every American a Health Security Card will not guarantee access to needed care. For many Americans, nonfinancial barriers to health care need to be removed as well, for those nonfinancial barriers vary from community to community and group to group.

At today's hearing we have invited representatives of many of America's special populations to give us their views on how well the Clinton plan addresses their particular needs and what improvements, if any, must be made in the bill to make it more effective. We will also want to know the implications of not enacting universal coverage as the President has proposed, but instead adopting legislation that does not entitle all Americans to comprehensive benefits.

We are pleased to call as our first witness, Kristine Gebbie, the National AIDS Policy Coordinator, and Judith Feder, the Principal Deputy Assistant Secretary for Planning and Evaluation.

This is Dr. Feder's fourth appearance before the subcommittee, and Ms. Gebbie's first in this capacity, although she has testified before us in years past as a State health officer.

We would like to welcome both of you to the subcommittee this morning. Without objections, your written statements will be part of the record in its entirety.

I would like to ask you to keep your initial remarks as brief as possible as we have a very large number of witnesses today and many questions to pursue with you and with them.

Dr. Feder, I understand you have some materials to submit to the subcommittee, so why don't we begin with you. We will by unanimous consent have opening statements from members inserted in the record and Mr. Bliley, who is our ranking Republican member, is on his way, stuck in traffic, and when he comes we will give him an opportunity to deliver his opening statement as well.

Dr. Feder, there is a button on the base of the mike, be sure to push it forward.

STATEMENTS OF JUDITH FEDER, PRINCIPAL DEPUTY ASSISTANT SECRETARY FOR PLANNING AND EVALUATION, DEPARTMENT OF HEALTH AND HUMAN SERVICES; AND KRISTINE GEBBIE, NATIONAL AIDS POLICY COORDINATOR, EXECUTIVE OFFICE OF THE PRESIDENT

Ms. FEDER. Thank you, Mr. Chairman.

As you noted, this is my fourth appearance before this committee. I wanted to begin the testimony by providing to you and members of the committee the information that you have requested with respect to the estimates of costs and the documentation on financing for the President's Health Security Act. And so we would just like to provide you those materials and include them in the record.

Mr. WAXMAN. Without objection, they will be received for the record.

[The information follows:]

December 9, 1993

ESTIMATING THE IMPACT OF HEALTH REFORM ON FEDERAL RECEIPTS

Executive Summary

The Treasury Department's Office of Tax Analysis (OTA) is responsible for preparing revenue estimates of proposals which affect Federal receipts. In general, OTA analyzes legislative proposals that change the Internal Revenue Code. OTA also analyzes the effects of certain legislative changes which do not amend the Internal Revenue Code but nonetheless affect Federal receipts. For example, changes in the laws concerning employer provision of certain fringe benefits can affect receipts because of the favorable tax status of such benefits.

The tax code also provides preferential treatment for certain types of health insurance expenditures. Health insurance contributions receive preferential tax treatment under several different provisions. Employer contributions for health insurance are deductible as a business expense by the employer and are excluded from the income of employees. Through their employers, some employees may have the option of contributing to tax-preferred cafeteria plans, enabling them to pay for their portion of health costs with pre-tax dollars. Self-employed individuals can deduct 25 percent of health insurance costs from adjusted gross income. Taxpayers can also deduct qualifying medical expenses which exceed 7.5 percent of their adjusted gross income. As a consequence, changes in the financing of health insurance will have implications for Federal receipts.

Estimating the effects of health reform on Federal receipts has required a cooperative effort among many agencies. The undertaking has demanded a broad understanding of the provisions contained in the proposal. Estimating the revenue impact of the proposal has required many data inputs from other Federal agencies involved in this process. To maintain consistency while estimating the costs of the health reform plan, the estimates of the revenue impact of the plan rely on certain inputs from other Federal agencies involved in this process. Because of the interaction among the provisions, a change in one or two of the basic underlying policy parameters could trigger significant changes in the revenue estimates.

The health reform plan contains many non-tax provisions which may affect Federal receipts by changing the financing of health care. Each of these provisions may have very different effects on revenues, but in combination the Administration's plan results in a net increase in Federal receipts over the budget period. An alternative plan with similar features could yield very different revenue results, even if it differed from the Administration's plan in only a few key non-tax aspects.

This technical note provides background as to the methods and assumptions underlying Treasury's estimates of the impact of health reform on Federal receipts. In preparing these estimates, Treasury followed long-standing estimating conventions accepted by both Administration and Congressional agencies responsible for producing estimates of the budgetary impact of legislative proposals. In analyzing the revenue impact of non-tax changes in the financing of health insurance, Treasury has used the same methodology and models which are used to estimate the effects of changes in Internal Revenue Code provisions on receipts.

Individual Tax Model

The Individual Tax Model (ITM) is one of the most powerful tools developed by OTA to aid in estimating changes in Federal receipts. The ITM is a large microdata simulation model. The microdata aspect of the model refers to the fact that it contains data on the income, deductions, health expenditures, and other characteristics of individual tax filing units and families. The model can simulate the taxes paid under both current law and proposed changes in law.

Professional economists in OTA construct, maintain, and utilize the ITM. OTA economists share a broad background in applied microeconomics, particularly in public finance. In addition, OTA economists are also specialists in other fields, such as econometrics, health economics, labor economics, statistics, and computer programming. These skills are used to develop the inputs to the model and for examining its outputs.

Interactions with Other Agencies with Interests in Tax and Health Policy Questions

OTA economists communicate regularly with their counterparts at the Joint Committee on Taxation (JCT) and the Congressional Budget Office (CBO), who also use large microsimulation models. Such contacts are useful both for identifying differences among the models as well as for developing consensus among the agencies responsible for analyzing the receipts effects of proposals.

In the health area, OTA staff maintains regular contact with numerous specialists. Members of OTA staff routinely discuss health modeling issues with staff from several agencies in the Department of Health and Human Services, including the Agency for Health Care Planning and Research (AHCPR), the Office of the Assistant Secretary of Planning and Evaluation (ASPE), and the Health Care Financing Administration (HCFA). In addition, OTA consults with health policy staff at the Council of Economic Advisers (CEA), the Office of Management and Budget (OMB), and the CBO.

OTA's extensive contacts with the staffs of other government agencies and outside experts provide additional access to data, research, and other techniques which are generally useful for model development. In many cases, these contacts are long-standing.

Description of the Individual Tax Model¹

Data: The current version of the ITM was constructed from a sample of 110,000 individual

¹ For a more detailed discussion of the Individual Tax Model, see James Cilke and Roy A. Wyscarver, The Treasury Individual Income Tax Simulation Model. Department of the Treasury, Office of Tax Analysis, March 1990.

income tax returns filed in 1989. The data base is a stratified probability sample of tax returns prepared by the Internal Revenue Service's Statistics of Income (SOI) Division.² This is the same sample employed by the SOI to produce the tabulations published in the Statistics of Income - 1989 Individual Income Tax Returns. When weighted, these data represent the total population of taxpayers in the United States.

Tax returns contain extensive information on the components of taxable income. In addition, tax returns provide information about taxpayers' marital status and family size. However, tax returns do not contain information on other demographic characteristics, on non-taxable forms of income such as welfare benefits or earnings on pension and other retirement savings, or on expenditures made by the taxpayer. Nor do tax returns provide any information on families outside the tax system.³ More comprehensive information than is provided on tax returns is needed to analyze the impact of proposals which extend the current income tax base and to analyze payroll, excise and other taxes.

To add more information, the SOI tax return data are first matched to age data from Social Security records and then statistically merged with records from the Current Population Survey (CPS) conducted annually by the Bureau of the Census. The records in the ITM are grouped into family units as well as income tax return units, and are weighted to represent the entire filing population and noninstitutionized nonfiling population. The SOI file is also statistically merged with records from the Bureau of Labor Statistics' Consumer Expenditure Survey. In addition, imputations of other critical income, asset, expenditure, employment, and demographic measures are made using a variety of sources (e.g., the Federal Reserve Board's Survey of Consumer Finances).

The data sources described above contain only limited information on expenditures on health care. From tax returns, information is available on the amount of health insurance purchased by self-employed persons who claim a 25 percent deduction. Tax returns also contain information on certain health expenditures, but only for those filers who itemize deductions and whose expenditures exceed 7.5 percent of their adjusted gross income. The Current Population Survey provides information on the insured status of individuals, including whether the insurance is provided through private or public sources. Lacking from these surveys is information on a family's total expenditures (including any employer contributions) on health insurance, characteristics of their insurance policy, and the health status of family members.

² Under Section 6103 of the Internal Revenue Code, OTA and JCT have access to tax return data, including the complete SOI file. A public-use computer tape file is available to other analysts, but it has fewer data items and taxpayer records and does not contain information which might violate the confidentiality of taxpayers. In particular, the public use file blurs information on high-income taxpayers.

³ Nonfilers are predominantly low-income persons who do not have an income tax liability and do not file a return to claim a refund.

To supplement these data sources, OTA statistically matched the data from the 1987 National Medical Expenditure Survey (NMES) to the ITM. The NMES is an extensive survey of approximately 14,000 households representing the civilian, noninstitutionalized population of the United States. It was conducted under the auspices of the Department of Health and Human Services' Agency for Health Care Planning and Research (AHCPR). The 1987 survey updates and expands previous surveys conducted in 1977 and 1980. The surveys collected information about participants' utilization and expenditures for health services, health insurance coverage, health status, and employment and income. Data from the household survey are supplemented by information from medical providers, employers, and insurers.

Extrapolation: The complete data file is then extrapolated to future years based on the economic forecasts used in the Budget.⁴ The extrapolation is done in two stages. The first stage adjusts for anticipated economic growth and inflation. This is accomplished by multiplying the various income, deduction, and credit items on each return by forecasts based on per-capita growth rates estimated from the economic forecasts. In the second stage, the weights assigned to the records in the file are changed to hit separately determined targets for key variables, including the size distribution of adjusted gross income.

The growth rates for health data are generally based on projections contained in the Federal Budget or the National Health Accounts. Where relevant, the targets reflect significant changes in participation or expenditures since 1987 (the base year for the NMES) or 1989 (the base year for the CPS). For example, a major expansion in Medicaid will affect participation rates during the mid-nineties. To ensure consistency with the Administration's Budget estimates, the Health Care Financing Administration's projections for persons insured by Medicaid are used to estimate targets in the extrapolation of these items in the ITM.

Tax Calculator: Using the extrapolated files, the tax laws for each year in the Budget period are simulated. In combination, these simulation programs are referred to as the "tax calculator" or simply, the "calculator." The calculator takes information from each potential tax filing unit in the data file, and using a set of specified tax parameters, computes that unit's Federal individual income tax liability under the proposed change in law.

Two basic revenue estimating assumptions are embedded in the calculator for computing tax liabilities. First, all filers are assumed to choose tax options which minimize their tax liabilities. Second, variables such as the level and distribution of total pre-tax income or total expenditures are held constant when simulating a tax policy change.

The calculator computes the values of a number of variables that are endogenous to the

⁴ At the time of the release of the Administration's health reform plan, the estimates were based on the Administration's economic assumptions contained in the 1993 mid-session review. The economic assumptions were extended through the year 2000 by OMB for purposes of determining the longer-term budgetary impact of health reform.

model -- that is, these are tax variables, in addition to liabilities, which may be affected by a proposal and which, in turn, can affect the calculation of tax liabilities. In general, the ITM can trace through most of the interactions between any income source and the various provisions of the Internal Revenue Code.

Appropriate behavioral responses have been incorporated into the tax model. In addition, as will be discussed further below, off-model adjustments are often made by the analysts to incorporate other anticipated behavioral changes in response to a proposed tax change.

Uses and Limitations of Model Output

As noted above, the ITM is a powerful tool which enables OTA economists to better analyze the effects of various proposals. There are several important distinctions, however, between the output of the tax model and the final analyses prepared by OTA.

First, even in the simplest case, output from the ITM does not go unexamined. Output is subject to a reality check. Users of the ITM check carefully the results to determine if they appear reasonable. For example, users may compare the extrapolation of a particular variable with data which has become available since the initial construction of the tax model. Such information may include data from more recent samples of tax returns (e.g., the 1991 SOI sample of tax returns), other government organizations (e.g., the Bureau of Labor Statistics' Surveys of Employee Benefits; the Census Department's Survey of Income and Program Participation), trade associations (e.g., surveys conducted by the Health Insurance Association of America), and independent consulting organizations.

Second, the ITM is best utilized to analyze the effects of changes in the tax code that affect broad groups of taxpayers and involve current law tax rules. The tax model cannot be relied upon exclusively to estimate changes in the tax code which affect narrow populations or introduce new income tax rules. In these instances, OTA economists may rely on "spreadsheet" models to produce estimates of tax changes. Often, these spreadsheet models are, themselves, quite extensive and sophisticated. In many cases, information from the ITM (e.g., the marginal tax rate faced by a comparable group of taxpayers) may be used as input into these spreadsheet models. The ITM is also not used to analyze proposals affecting tax units other than individuals. For these purposes, OTA maintains several other tax models, including a corporate model, a depreciation model, and an estate model.

Third, subject to certain budget estimating conventions, estimates of the revenue effects of tax changes include assumptions about changes in taxpayers' behavior induced by changes in tax policy. Given the set of macroeconomic assumptions used to prepare the Budget, major GDP components -- such as real and nominal GDP -- are assumed to be fixed for purposes of estimating the deficit impact of a proposed change in legislation. Thus, for revenue estimates, behavioral effects are constrained by this "fixed GDP" assumption. Behavioral assumptions which affect the composition of GDP, but not its level, are integral to the revenue estimates.

Off-model adjustments are generally necessary to account for the full range of potential behavioral effects.

Fixed GDP Assumption

The "fixed GDP" budget estimating convention is a long standing rule and is followed by the Office of Management and Budget, Treasury, and all other Executive Branch agencies. The Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) follow a similar convention, using the economic assumptions contained in CBO's budget analyses. The "fixed GDP" assumption allows policymakers to view the effects of proposed change in law on the deficit, as forecasted in the most recent Budget.⁵ Without such a convention, dozens of analysts in each agency could derive their own independent forecast of GDP each time they estimated the deficit impact of a proposed change in legislation.⁶

As a consequence of the fixed GDP assumption, Treasury, CBO, and JCT assume that total employee compensation remains unchanged in response to a requirement that employers provide a new fringe benefit to their workers. This identity is derived from the Census Bureau's National Income Accounts (NIA). Under these assumptions, if employer contributions for health insurance increase, then other forms of labor income -- wages or other fringe benefits - must decline in order for GDP to remain constant.⁷ However, if wages and salaries decline, income taxes and employment taxes must decline as well. This effect is sometimes referred to as the "income offset."⁸

⁵ Under the Budget Enforcement Act of 1990, the estimates of legislative proposals are based on the economic assumptions contained in the President's Budget. At the time of the introduction of the Administration's health reform bill in the fall of 1993, it did not seem likely that the legislative action would be completed by the end of the year. As a consequence, there was an Administration-wide decision to use the recent economic assumptions contained in the Mid-session review.

⁶ The fixed GDP assumption is discussed in detail in Howard W. Nester, "A Guide to Interpreting the Dynamic Elements of Revenue Estimates." Compendium of Tax Research 1987, C. Eugene Steuerle and Thomas Neubig, eds. Washington, D.C.: Government Financing Office, 1987, pp. 13 - 41.

⁷ Some benefits -- such as employer contributions for social insurance -- are linked by law to wages and thus change as wages change.

⁸ For a discussion of the "income offset," see George Tolley and C. Eugene Steuerle, "The Effects of Excises on the Taxation and Measurement of Income," 1978 Compendium of Tax Research. Washington, D.C.: Government Printing Office, 1978, pp. 67 - 78; and Sonia Conly and Linda Radey, "Changes in Excise and Payroll Taxes and Their Effect on Total Budget Receipts," paper presented at the 1988 Eastern Economic Association Meetings, Boston,

Federal income and employment tax liabilities are affected by these compositional changes, as the allocation between taxable cash wages and non-taxable compensation (including the employer portion of payroll taxes) shifts. Based on observable relationships within the NIA, wages and salaries would appear to fall by almost the full amount of an increase in employer contributions for health insurance. Wages and salaries do not fall by the full amount for several reasons. First, the reduction in wages automatically causes employer contributions for social insurance (another form of labor compensation) to decline. Further, to some extent, employer contributions for other fringe benefits, such as pensions and life insurance, will also fall.

Estimating the Effect of Required Employer Contributions for Health Insurance, Premium Discounts, and Cost Containment on Federal Receipts

Under the health reform plan, employers would be required to contribute towards the purchase of a comprehensive health insurance benefit plan for their workers. This package may cost either more or less than the health insurance plan currently provided by the firm, and its scope may also differ markedly from the firm's current plan. Employers' response to a requirement that they contribute toward their employees' health insurance will depend, in large part, on how the guaranteed comprehensive benefit package differs both in costs and generosity from their current plans and the extent to which they may be entitled to premium discounts under the proposal.⁹

Five key pieces of information are necessary to evaluate the impact of the health reform proposal on Federal receipts. These include:

- Initial cost of the comprehensive benefit package;
- Rate of growth in the cost of the comprehensive benefit package;
- Degree to which employers' costs are offset by premium discounts;
- Employees' demand for health insurance in excess of the comprehensive benefit package; and

Massachusetts.

⁹ The health reform plan affects revenues largely through its impact on the allocation between taxable wages and non-taxable health benefits. The plan can affect revenues in other ways as well. As insurance coverage expands as a consequence of the plan, some taxpayers will not incur large out-of-pocket expenditures for uncovered medical expenses, and deductible medical expenditures will also fall. Expansion of the Medicare benefit package to include prescription drugs may also reduce deductions for medical expenses.

- **Employees' ability to negotiate with employers to obtain tax-preferred methods of paying for supplemental coverage and the employee share of the cost of the comprehensive benefit plans.**

The data sources and the key underlying assumptions for each of these items are described briefly below.

Costs of the Benefit Package: The Health Care Financing Administration (HCFA) provided estimates of the costs of the benefit package at 1994 levels, assuming that the plan was fully effective in that year. Their estimates included the effects of moving to a system of universal coverage.

Rate of Growth in the Costs of the Benefit Package: All agencies involved in estimating the budgetary impact of the health reform plan used the same assumptions regarding the rate of growth in the cost of the benefit package. Under these assumptions, the basic benefit package was assumed to grow at a rate consistent with private health insurance between 1994 and 1996. Beginning in 1996, the costs of the plan were assumed to grow at the targeted rates of growth specified in the health reform plan (CPI+1.5 percentage points in 1996, CPI+1.0 percentage points in 1997, CPI+0.5 percentage points in 1998, and CPI in 1999 and 2000). These rates of growth are based on the assumption that the cost containment initiatives contained in the plan are effective.

Premium Discounts: Under the plan, premium discounts are provided to ease the burden for some employers. First, small firms with fewer than 75 employees and average wages below \$24,000 will be entitled to significant premium discounts. Second, the Federal government will provide premium discounts for other firms within the regional alliance if the cost of providing the comprehensive benefit package exceeds 7.9 percent of their payroll. Some employers will receive premium discounts even though they provided health insurance in the past. These employers are expected to pass the discounts back to workers in the form of higher wages and other benefits. Receipt of premium discounts, then, could affect the estimates of the plan on Federal receipts.

HCFA is responsible for producing the official estimates of the costs of the premium discounts. Using Treasury's Individual Tax Model, it is also possible to simulate the receipt of the premium discounts by individuals (as passed back to them by their employers). Treasury's estimates of the premium discounts were used solely as an input into the analysis of the effect of the plan on Federal receipts. As a check, OTA's estimates of the premium discounts are reconciled to those produced by HCFA.

Demand for Supplemental Coverage: Workers' demand for supplemental coverage is estimated largely as a function of expenditures on medical services for items not within the scope of the comprehensive benefit package. Data on reimbursable expenditures on health insurance, as well as current health insurance expenditures, are used to determine the value of supplemental health insurance coverage. Estimates of the costs of administering health insurance (the "load

factor") under the current system were provided by HCFA. The estimates also account for changes in the price and demand for supplemental coverage following health reform.

Cafeteria Plans and Other Tax-Preferred Arrangements with Employers: Under the Administration's health plan, individuals may be responsible for a portion of the cost of the comprehensive benefit package. They may be liable for the difference between the cost of the plan which they select and eighty percent of the weighted average cost of a plan within their region. As under current law, workers are generally required to pay for health insurance premiums out of after-tax income. However, the current system provides workers with several opportunities to reduce their health insurance costs by paying with pre-tax dollars. To the extent that workers can take advantage of these options, tax receipts will fall.¹⁰

The estimates of the required employer contribution (with premium discounts and cost containment) took into account the likelihood that individuals may seek ways to shelter, on net, more of their health insurance premiums through cafeteria plans and other informal arrangements with employers. The estimates also took into account other offsetting factors (such as some reductions in contributions which, under the current system, cover out-of-pocket reimbursements).

Estimating the Effect of Restricting Contributions for Health Insurance

Under the plan, employer contributions for the comprehensive (i.e., standard) benefit package (up to 100 percent of the costs of the package) would be excluded from income for purposes of calculating individual income and employment taxes. Employer-paid premiums on supplemental plans would now be included in employees' taxable income.

While this provision would generally become effective January 1, 2004, contributions for health benefits through cafeteria plans would be disallowed, effective January 1, 1997. As a consequence, the seven-year estimates of the revenue impact of health reform only show the impact of the restrictions on employer contributions through cafeteria plans.

OTA's estimates of the effects of the restrictions on cafeteria plans are "stacked" after the combined effects of the required employer contribution, cost containment, and subsidies have been taken into account. In other words, the baseline for cafeteria plans, in these estimates, assume that individuals have already made certain adjustments to other aspects of health reform. Thus, for example, the baseline would reflect changes in the utilization of the cafeteria plans in response to the required employer contribution.

When contributions to cafeteria plans are restricted, individuals may have alternative opportunities to shelter income through other tax-preferred arrangements with their employers (e.g., the employer may agree to pay the full amount of the employee contribution and, in turn, explicitly reduce wages by an offsetting amount). These alternatives for sheltering income are taken into account in the revenue estimates for restricting cafeteria plans.

¹⁰ As will be discussed further below, the Administration's plan would restrict contributions to cafeteria plans. The estimates of the effects of the required employer contribution do not reflect these proposed restrictions. The effects of these restrictions are estimated separately, under the assumption that employee behavior has changed in the ways described in this section.

STATEMENT OF KRISTINE GEBBIE

Ms. GEBBIE. Mr. Chairman, I am very pleased—very pleased to be here today in this new capacity as AIDS Policy Coordinator and very happy to have a chance to talk with you and members of the committee about the impact of the President's health plan on people with special needs; those with HIV, people with disabilities, Native Americans, rural residents, migrants and others.

I will obviously focus on those with HIV, although a number of the issues overlap. These diverse individuals have unique and special gifts and characteristics, but they have one thing in common with all other citizens, and that is their right to secure health care that they and their families can depend on.

The system that we have today leaves many of these people behind. It is a system that works reasonably well if you are reasonably healthy, reasonably insured or reasonably wealthy, but a system that falls short for millions of Americans who don't quite fit that mold. As individuals and a Nation, we can no longer afford to leave people out in the cold just because they are labeled a "bad risk." And I want to specifically focus on what this plan will do to help these individuals. The Health Security Act doesn't offer miracles of a cure and cannot alleviate all of the personal pain and suffering that often accompanies a chronic illness or condition, but it can offer secure health coverage for everyone, health care that is always there.

Two stories about real people who have a chronic illness, HIV infection, and how their experiences in the present system give, from my point of view, real fuel to the fire to get moving on this. There are no guarantees in the present system.

One is the story of Christina, a 25-year-old, who was covered under her father's insurance policy while she was a college student. It was during that time that she tested positive for HIV. When her father disclosed this to his self-insured company, they tried several strategies to get her off the coverage. They finally solved their problem, they fired her father, leaving her to try and find her coverage on her own.

Charles is an individual who does have coverage, but doesn't feel very good about what he has to do to keep it. He is 37 years old and was diagnosed with AIDS in 1985. At that time he was working but in a system—in a place that had no insurance and he could not afford the premiums to buy his own coverage. When he found out he was HIV positive, he knew he would need help with his expenses and after checking several places, he turned to social security for help, applied for disability and Medicaid, and in doing so had to quit his job, which is how the system fails to work for many people.

He would like to work, he is physically able to work, but in order to have—at least part of the time, not fully—but in order to have his \$4,000 monthly medication bill covered, he has to stay unemployed and defined as disabled, caught in a trap, always fearful that today would be the day that this house of cards collapses on him.

The Health Security Act offers relief, universal coverage, that means everybody, Charles and Christina and all the ones like them. These people will never lose their coverage for the crime of

being too sick, won't face up to a lifetime limit or exclusion, not lose their job over the need for insurance, will never have to lie or impoverish themselves to get something we believe is a fundamental right.

There are several features of the Health Security Act that are of great significance to people with HIV and AIDS: One, that preexisting conditions such as testing HIV positive will not exclude someone from coverage. It is a universal program. Two, that medical specialists trained to treat people with HIV and AIDS will be deemed essential providers and thus will be available to those who need them. Three, that prescription drugs, which are a significant cost for people with HIV and AIDS, will be covered under the plan. Four, that discrimination, redlining and other means used currently to prevent coverage for some persons with special needs will be eliminated under the President's plan. Fifth, that confidentiality, a concern for all of us, but a particular concern for those with HIV infection, will be protected and guaranteed under the act.

Finally, that the Ryan White Care Act will remain as a safety net to provide needed supplemental services to people with AIDS. Those are services such as community-based home care beyond what the plan provides, case management, transportation, nutrition, housing and other services.

The administration is making the care and treatment of people with special needs a priority. Last week, the Public Health Service released its new HIV treatment guidelines for use by health care providers nationally. These highlight the essential services in the early treatment of HIV, and they provide the kind of guideline that can be used under the plan to assure appropriate treatment. It is also important, and I would be remiss if I didn't mention that the plan has a part of it to improve the Nation's public health system and at the same time personal health benefits are extended to all.

HIV infection is preventable, as are many of the other conditions which cause an individual to become disabled or enter a special population. We need to make every effort to prevent these conditions from occurring in the first place, and the proposed public health improvements that are supported in the proposal will allow rebuilding an infrastructure in our prevention agencies so that those agencies can be real partners with the personal care system and be responsive to community needs.

Mr. Chairman and members of the committee, 37 million Americans, including many people who have special needs, go without health coverage today. Far too many people most in need of services, such as those with HIV infection, are underinsured, or lose their insurance just when they need it most.

We either address the problem head on by organizing care delivery and financing so it works, or continue to deny the problem and let the system grow more unfair, expensive and out of control. We need to join forces to make this work and have a rational system where those who need care have secured care that is always there.

As you mentioned earlier, you have a complete longer text of my full testimony that covers more details on these and other matters, and I would be very happy to discuss any questions you have.

[The prepared statement of Ms. Gebbie follows:]

Testimony of

Kristine Gebbie, R.N., M.N.

National AIDS Policy Coordinator

Executive Office of the President

Mr. Chairman and members of the Committee, thank you very much for this opportunity to share with you what the President's plan will do to help vulnerable populations -- those with HIV/AIDS, people with disabilities, Native Americans, migrant workers and others.

Their special circumstances, illnesses, and disabilities amplify their needs and illustrate poignantly the failures of the current system to provide the security of coverage when help is needed the most.

I'd like to share with you the stories of some real people, to illustrate how devastating a chronic illness -- in this case HIV/AIDS -- can be. As you'll see, because these people could be any one of us here in this room today, there are no guarantees in the system for any of us.

Christina, a 25 year old woman, was covered under her father's insurance policy while she was a college student. During this time, she tested positive for HIV, the virus that causes AIDS. When her father disclosed this to his self-insured company, they pursued several strategies to get Christina off company policy. Finally, the company solved its problem by firing Christina's father.

Charles has coverage but he doesn't feel very good about what he has to do to keep it. Charles is a 37 year old male who was diagnosed with AIDS in 1985. At the time he was working and had no insurance because he couldn't afford the high premiums. He knew he would need some help with his medical expenses, so he turned to Social Security for help. Charles quit his job in order to apply for disability and Medicaid. Charles would like to work, but in order to have his \$4,000 a month medical bills covered, he had to stay unemployed and disabled. Charles feels that he is "caught in a trap" and fears the day when "the day the house of cards will collapse."

Fortunately, the President's plan provides universal coverage for every American, and that includes all the Charles's and Christina's out there, regardless of their needs or risks.

Congress -- particularly members of this Committee -- has demonstrated great concern about the ability of underserved populations to obtain access to health care services. The President recognizes, as you do, that a Health Security Card alone cannot guarantee that all Americans will receive necessary health care services. To achieve this goal, the Health Security Act includes additional measure that will provide special protections and secure access and quality for our vulnerable populations. Let me share them with you.

Security of Comprehensive Coverage

All Americans will have the security of comprehensive health coverage -- with no exceptions. People with disabilities or chronic illnesses will no longer be subject to the precipitous loss of coverage they face today. No one can lose their coverage. Under the Health Security Act, hospital services are covered; doctor visits are covered; prescription drugs are covered. In addition, certain extended care, hospice services, and outpatient rehabilitation services are covered. These services, and others offered under the benefit package become a crucial link for the very survival of people with certain disabilities or illnesses.

Mental illness and substance abuse treatment services are guaranteed elements of the comprehensive benefits package. By 2001, this coverage is without day or visit limitations -- on the same terms as other services.

From the onset, mental illness and substance abuse treatment benefits covered by the Health Security Plan (within certain guidelines and criteria) include: screening and assessment; inpatient and residential treatment; crisis services; intensive non-residential treatment; outpatient treatment; collateral services; and case management. Benefits are provided in variety of settings, including offices and clinics, residential treatment and intensive non-residential programs.

Continuity of Care

The Health Security Act assures that all Americans will have a choice in selecting their providers and health plans. Each individual will be able to enroll in a traditional fee-for-service plan, join a network of doctors and hospitals, or join an HMO. In addition, all health plans must offer a point-of-service option -- individuals will not be restricted to the plan providers.

To further guarantee continuity of care, all individuals will have access to medical specialists for unique services they need. All health plans must sufficient arrangements with providers to assure the provision of all items and services covered by the comprehensive benefit package. In addition, plans must contract with academic health centers for services that are rare and performed in enough frequency at these sites to ensure quality. Further, states may require plans to contract with centers of excellence they identify to further guarantee appropriate access to care.

The essential community provider provision guarantee services of federally-funded clinics and other providers delivering care in difficult-to-serve areas. Qualifying providers, e.g.

those being funded by Ryan White, Community and Migrant Health Centers, programs for the Homeless, family planning, and maternal and child health, are guaranteed payments for covered services from all health plans. This program assures that vulnerable populations have continued access to practitioners with experience in meeting their needs, regardless of which health plan they choose to enroll in.

Protections Against Discrimination

The Health Security Act assures that no individual is discriminated against in obtaining comprehensive coverage. Health plans will no longer have lifetime limits on coverage. Health plans will offer an open enrollment, accepting everyone applying for coverage at that time without charging a higher premium to those with a pre-existing condition. States and alliances further assure that no one faces barriers to care based on race, ethnicity, sexual orientation, age or gender.

To protect health plans that attract disproportionate number of vulnerable individuals, the Health Security Act assures proper payment through an alliance-based risk-adjustment and reinsurance systems.

To ensure confidentiality of patients, national privacy protection standards are established. These standards forbid the linkage of individual-specific information with aggregate data on patterns of care. Privacy protection as applied to health care information will be a continuing focus of the National Health Board.

Special Services

The Health Security Act leaves in place certain programs to address additional needs of these vulnerable populations.

Ryan White and other safety net providers. Current safety-net programs like Ryan White will continue to receive funding for services beyond the guaranteed package. Transportation, outreach, case management, translation, and personal support services remain critical for vulnerable populations and will be sustained under the Health Security Act.

Medicaid. All Medicaid eligible children will be eligible for a new federal program of wrap-around services that supplements the comprehensive benefits package. States will continue to receive matching payments for wrap around services for adults who receive SSI or AFDC benefits and dual eligible. Long term care Medicaid services (e.g., nursing home, ICF/MR, home health, personal care, etc.) continue to be available for all Medicaid eligible as under current law. In addition, all states will be required to take Medicaid expenditures into account in determining financial eligibility for Medicaid coverage of nursing home care. Also, Medicaid patients in institutions will be able to keep \$50 per month for their personal needs, up from a minimum of \$30 per month.

Transitional Insurance Reform

As you know, the reform will take a few years to fully implement. During the interim it is critical that we protect existing insurance coverage for employers and families. We must

assure that insurers do not drop the most vulnerable in anticipation of a system in which they are forced to compete based on price and quality, rather than their ability to attract the healthy and avoid the sick.

The Health Security Act, therefore, includes a series of transitional insurance reforms that guard against the most egregious abuses by health insurers prior to the creation of a fully reformed market and the formation of health alliances. These reforms include:

- Health insurers are prohibited from terminating or failing to renew coverage for a group or individual, except in cases of non-payment of premiums, fraud, or misrepresentation in an application for coverage or claim for benefits.
- Insurers are required to provide coverage for new employees of an employer that purchases insurance, regardless of health status.
- Premium increases cannot be varied according to the health status of the group or individual.
- Exclusions for pre-existing conditions are limited, and individuals who are continuously insured are not required to meet a new waiting period for pre-existing conditions when switching coverage.
- Self-insured health plans may not arbitrarily reduce benefits for high cost illnesses.
- The National Transitional Health Insurance Risk Pool is established to provide coverage to individuals who are unable to obtain private coverage because of their health status.
- Insurers are required to obtain prior approval for excessive premium increases.

These transitional insurance reform by no means represent comprehensive reform, as ultimately envisioned by the Health Security Act. They will, however, protect against the most extreme abuses we see in the insurance market today, and they will ensure an orderly transition

to a system that guarantees health security for all Americans and effective control of health costs.

Other Special Programs

School-Age Youth. The Health Security Act will address the problems of one of our Nation's most vulnerable groups: adolescents and young adults. The current health care system has failed to provide our youth with the information and services they need to avoid risky behaviors and make healthy decisions. Adolescents are also often reluctant to seek help, ignorant about what help is needed or where to get it, and concerned about confidentiality. These barriers contribute to the substantial problems with substance abuse, unwanted pregnancy, and HIV/AIDS among this age group.

The Health Security Act will reach out to school-age youth and adolescents in two ways. The Comprehensive School Health Education initiative will establish a national framework within which States can create school health education programs that improve the health and well being of students, grades K through 12, by addressing locally relevant priorities and reducing behavior patterns associated with preventable morbidity and mortality. This program will be targeted to areas with high needs, including poverty, births to adolescents, and sexually-transmitted diseases among school-aged youth.

The School-Related Services program will support the provision of health services -- including psychosocial services and counseling in disease prevention, health promotion, and

individualized risk behavior -- in school-based or school-linked sites. Grants will be made to states for the development and implementation of state-wide projects targeted at high-risk youth ages 10-19. In states that do not take this initiative, grants will be available to local community partnerships including public schools, experienced providers, and community organization

Severely Disabled Persons. The plan also includes a major expansion of home and community based services for individuals with severe disabilities. This new long term care program will offer significantly increased federal funding to help states to offer a wide array of personal assistance and related supports to people at home, in the community. Eligibility for this program is not limited by age, type of disability, or income. When this program is fully phased in, approximately \$38.5 billion new federal dollars will be available to help people who have significant needs for assistance with activities of daily living to live more independent lives.

Migrant Workers. Migrant Workers are guaranteed a new level of health security under the Act. With their health security card, legal residents employed as migrant workers will be able to easily transfer their coverage from one geographic area to another. In fact, the portability will be assured by regional alliances whose job it is to keep track of employer payments and enrollment for all workers.

The Public Health Service Initiatives in the Act also provide a supportive framework for the benefit package coverage that is assured. The Community and Migrant Health Center Program is maintained, and as you know, Mr. Chairman, Migrant Health Centers are an

important source of primary health care for many migrant workers throughout the nation. These Migrant Health Centers are also protected as Essential Community Providers for at least the first five years of health care reform. The PHS Initiatives also contain a new grant program to assist providers in offering support services that will make their services more accessible, including transportation, outreach, and translation services. These services will be very important in helping providers offer more culturally appropriate services for migrant workers.

Indian health. American Indians/Alaska Natives receive special treatment under the Health Security Act in recognition of the historic obligations of the government-to-government relations that exist between the Federal government and Indian tribes.

Under the Act, Indians will receive an improved benefit package and new choices of providers. Indians may choose to enroll either with an Indian health program or with a health plan offered by an alliance. The health programs of the Indian Health Service will be maintained and expanded so that they will be able to offer the full range of the comprehensive benefit package services by 1999. All Indians, whether they enroll with an Indian health plan or an alliance health plan will remain eligible for supplemental services, such as environmental health, outreach, transportation, etc. The PHS Initiatives will reaffirm the emphasis on these important services.

Conclusion

Mr. Chairman, Members of the Committee: 37 million Americans, including many people who have special needs, go without health coverage. Far too many people most in need of services, such as those with HIV infection, are uninsured, or lose their insurance just when they need it most. We can either address the problem head on -- organize health care delivery and financing, so that system works for all Americans -- or deny the problem and let the system grow more and more unfair, expensive, and out of control. We must join forces and solve this problem. We must work together to create a rational system where those who need health care the most have security of care.

Mr. WAXMAN. Thank you very much for your testimony.

And, Dr. Feder, we are pleased you are here to not only give us the information for the record but to answer questions.

Certainly for people with HIV or AIDS, having this health bill is going to be of tremendous importance, as well as to all Americans who do not have health insurance coverage. But people who have AIDS or certain disabilities have an additional concern other than just having coverage. Because if they need specialized care from experienced practitioners or specialists, they have to have access to those people. And if all they can afford is to be in an HMO, and that HMO doesn't have a specialist who can take care of those specialized needs, they may well find themselves without the care they desperately need. And for low-income people this is going to be an especially difficult problem, because if they are in a managed care plan, even if they can go outside of the managed care plan to get services of a specialist, they will have to bear that additional cost.

How would you guarantee that people with these specialized needs get the specialized services that they do need, whether it is AIDS or some other disability?

Ms. GEBBIE. To answer that specifically around HIV infection and AIDS, I think there are two pieces of the plan that are designed to give that assurance. The first is the creation of the essential providers category. A very large percentage of those now providing specialized care to HIV-infected people are being reimbursed through the Ryan White Care Act, which makes them definable as an essential provider and requires that they be included for reimbursement by plans, so that people now under their care can continue there.

In addition, there is every incentive for a plan to give proper care to people because giving bad care to anyone, including someone who is HIV infected, only raises the cost, causes hospitalizations, and is a disadvantage to the plan. And I believe that plans will see it in their interest to assure that they have the appropriate specialists for any condition. Use of things like the guidelines for care that point out how to provide early, appropriately inexpensive early care as a part of a complete managed plan makes it easier for them to see and understand that.

Mr. WAXMAN. I would guess a plan would have another incentive not to provide specialists for chronically ill people, so the chronically ill people won't sign up in their plan. Won't they hope that they are not chosen by disabled people? Because obviously the care that chronically ill or disabled people will need will cost that plan more money.

Ms. FEDER. Mr. Chairman, the fundamental requirement of all plans, whether they are HMO's or fee-for-service plans, is that they provide all their enrollees access to necessary or appropriate services, that includes specialty services, and plans must provide that access. That is why we have requirements that they deal not only with essential providers, but also that they must contract with an academic health center and that they may be required by States to contract with Centers of Excellence.

So in terms of the availability of services they are guaranteed, in terms of the incentives, you rightly raise that we must pay ap-

propriately for the patients that a plan actually serves. And it is for that reason that the President's plan includes the risk adjustments and reinsurance to make certain that services are appropriately financed. And finally, any measures taken that prove to be discriminatory, are prohibited.

Mr. WAXMAN. Will HIV status be a part of risk adjustment?

Ms. FEDER. When we talk essentially about risk adjustment, we do look at health status factors. And so that is certainly an appropriate factor to take into account.

Mr. WAXMAN. Now, it is not unusual for a family with an income of \$35,000 a year to care for a child with severe medical or developmental complications at home, to require services that can cost as much as \$100,000 a year. Such a family would have to spend more than \$25,000 to meet the copay requirements of the Clinton home-based care benefit.

Does the administration really see this copay structure as realistic for such a family without a ceiling on out-of-pocket costs?

Ms. FEDER. I think what the question raises, Mr. Chairman, is in our home and community-based care program, there are cost-sharing requirements that do vary with income. And we have not put a limit on those.

It is our view that that program represents a vast improvement in the affordability of services. We recognize that it may not address all needs, but we believe it is a very significant and vital first step.

Mr. WAXMAN. Thank you.

Mr. Greenwood.

Mr. GREENWOOD. Thank you, Mr. Chairman.

It seems that when we talk about the HIV and AIDS populations and ensuring health coverage into the future, that the issue of exclusionary rates versus community rating is the critical issue, we want to make sure the health status of the individual does not impede his or her ability to get health care.

We are rapidly approaching the time when this subcommittee has to start making some choices in terms of the legislation before us, and so I would like to ask each of you, or either of you, to let us know where you think that the Cooper plan and/or the Michel plan fall short in those regards for this population.

Ms. FEDER. The critical issue is guaranteeing coverage that is always there. Neither of the proposals that you mentioned guarantees that coverage. They both, in different ways, make improvements in the current marketplace. But they do not guarantee that protection is sustained when people's circumstances change. So that if a person becomes ill and their employer chooses not to provide coverage, or they lose their job, they are left on their own to purchase that coverage.

And no matter what changes we make in the rules for insurance, there is no guarantee that coverage will be affordable for people who find themselves in those circumstances. Consequently, we would argue that we need a comprehensive proposal that guarantees that people have coverage, whether they are sick, well, working, not working, whatever their circumstances. And that is what the President's proposal does.

Mr. GREENWOOD. And are we not talking about community rating when we talk about making sure that the health care coverage is affordable?

Ms. FEDER. The rating pieces are part of that, changing the rules for the way in which insurers may distinguish among people based on their circumstances. And that helps somewhat. But if the coverage is not guaranteed as affordable, or if affordability is not guaranteed, then we cannot guarantee that people will be able to pay whatever rate the insurer is charging.

In a voluntary market, where there is no requirement that everybody have coverage, and it is not guaranteed, and we require insurers to community rate, essentially, we would see an increase in the risk that insurers face. People are most likely to buy when they are sick. In that circumstance, insurers are likely to hike their rates further to protect themselves from that kind of circumstance and everyone's rates will rise. And that is a problem we face in a situation in which we don't have everybody purchasing coverage.

Mr. GREENWOOD. So are you saying that it is your analysis that the Cooper bill, the Michel bill and the Clinton proposal, all through community rating and prohibitions on exclusions, allow these populations in? Is the single major difference the fact that they are not required to be in at all times?

Ms. FEDER. I would want to double-check on the provisions of the Michel bill. And I actually think that it would be useful for us to provide an answer in full for the record on this. But I think that whatever changes one makes in those rules, one is not guaranteeing security unless that coverage is guaranteed to always be there and to be affordable.

Mr. GREENWOOD. OK. Well, I would appreciate it if you would do that. If you, Judy, would be so kind as to provide my staff with that comparison; it would be most useful. And I think not only with regard to the HIV and AIDS populations, but some of the other special populations that we are addressing today.

Ms. FEDER. I would be happy to.

Mr. GREENWOOD. If you would do a side-by-side.

[The information follows:]

H.R. 3600/S. 1767 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wellsstone)	H.R. 3040/S. 1533 (Micheli/Lott)	H.R. 9222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nickles)	H.R. 3764/S. 1770 (W. Thomas/Chafee)
B. Availability	B. Availability	B. Availability	B. Availability	B. Availability	B. Availability
<p>A certified plan would have to accept every eligible person enrolled by an alliance and could not terminate or limit coverage for the comprehensive benefit package. No plan could engage in any practice that had the effect of attracting or limiting enrollees on the basis of personal characteristics, anticipated need for health care, age, occupation, or affiliation with any person or entity. Also, a plan could not discriminate or engage in any activity, including the selection of service area, that had the effect of discriminating against an individual for those and other specified reasons. Further, a plan could not discriminate on such bases in the selection of providers for its network. With State approval, a plan could limit enrollment on the basis of its capacity and/or financial</p>	<p>States could ensure availability of insurance to small employers through guaranteed issue (must accept all eligible applicants) or guaranteed availability (must ensure that there is a source of insurance for those eligible and wanting to buy). Under a guaranteed issue approach, all insurers selling in the small group market would have to offer health insurance coverage to each small employer in a State through a MedAccess standard, catastrophic, and medigap plans. Insurers offering MedAccess plans to small employers would be required to accept every small employer who applied for coverage and every eligible individual who applied for enrollment during open enrollment periods or within 30 days of losing previous employer coverage. (Federally qualified and</p>	<p>Open AHPs would have to have an agreement with each HPPC for each HPPC area in which they are offered. In general, an open AHP would have to accept all eligible individuals who applied for coverage (i.e., eligible employees of small employers and eligible individuals not obtaining insurance through an employer) during an open enrollment period. Coverage could not be refused or terminated except for cause (e.g., nonpayment of premiums, fraud or misrepresentation, or plan termination). Network AHPs could deny coverage for an eligible individual if the person lived outside the network area, or if the plan had reached capacity, but only if such denials were applied uniformly, without regard to or insurability.</p>	<p>On or after January 1, 1998, all qualified health plans would have to sell insurance to all applicants at standard rates (see "Rating" below) and could not cancel or refuse to renew coverage except for cases of nonpayment of premiums, or fraud or misrepresentation on the part of the policy holder.</p>	<p>Qualified general access plans. Once market reforms were enforced by the States, an insurer could not exclude from coverage or any eligible employee or eligible individual applying for coverage. It could not deny, limit, or condition coverage under (or the benefits of) the plan based on the health status, claims experience, receipt of medical care, execution of an advanced directive, medical history or lack of insurability, of an individual.</p>	<p>An insurer would have to offer qualified general access plans throughout an entire HCCA area. (The insurer could deny coverage under the plan to eligible persons who reside outside the HCCA in which such plan was offered but only if such denial was applied uniformly, without regard to</p>

H.R. 3600/S. 1757 (Administration plan)	H.R. 1200/S. 491 (McDermott/Wallatone)	H.R. 3080/S. 1533 (Michel/Lott)	H.R. 3222/S. 1579 (Cooper/Breaux)	H.R. 3698/S. 1743 (Stearns/Nichols)	H.R. 3704/S. 1770 (W. Thomas/Chafee)
<p>stability, but only if enrollment was limited uniformly, without regard to insurability.</p> <p>During the period of transitional reforms, an insurer could not cancel a policy that was enforce on the date of enactment of an individual or group.</p>	<p>certain other health maintenance organizations (HMOs) would be exempt from this requirement under specific conditions.)</p> <p>Under a qualified availability approach, a State could set up a mechanism under which insurers participating in the small group market would have to participate in an assigned risk pool among some or all insurers (see "reinsurance" below) and ensure that through this pool, small employers have access to a MedAccess standard, catastrophic, and medigap plans.</p>	<p>certain other health maintenance organizations (HMOs) would be exempt from this requirement under specific conditions.)</p> <p>Under a qualified availability approach, a State could set up a mechanism under which insurers participating in the small group market would have to participate in an assigned risk pool among some or all insurers (see "reinsurance" below) and ensure that through this pool, small employers have access to a MedAccess standard, catastrophic, and medigap plans.</p>	<p>insurability. In addition, an insurer could apply to the certifying authority (State or Secretary) to limit enrollment in a plan under specific conditions such as limited capacity.)</p> <p>Qualified access plans would have to be renewed at the employer or enrollee's option unless the plan was terminated for cause (nonpayment of premiums; fraud or misrepresentation; or change in residence to a HCCA not served under the plan). An insurer could terminate a qualified general access plan made available through a specific type of delivery system (such as an HMO) if it does so uniformly across the HCCA and provide adequate notice. In this event, it could not market such a policy in the State for five years.</p> <p>During the transition period, an insurer could deny enrollment to</p>	<p>insurability. In addition, an insurer could apply to the certifying authority (State or Secretary) to limit enrollment in a plan under specific conditions such as limited capacity.)</p> <p>Qualified access plans would have to be renewed at the employer or enrollee's option unless the plan was terminated for cause (nonpayment of premiums; fraud or misrepresentation; or change in residence to a HCCA not served under the plan). An insurer could terminate a qualified general access plan made available through a specific type of delivery system (such as an HMO) if it does so uniformly across the HCCA and provide adequate notice. In this event, it could not market such a policy in the State for five years.</p> <p>During the transition period, an insurer could deny enrollment to</p>	<p>insurability. In addition, an insurer could apply to the certifying authority (State or Secretary) to limit enrollment in a plan under specific conditions such as limited capacity.)</p> <p>Qualified access plans would have to be renewed at the employer or enrollee's option unless the plan was terminated for cause (nonpayment of premiums; fraud or misrepresentation; or change in residence to a HCCA not served under the plan). An insurer could terminate a qualified general access plan made available through a specific type of delivery system (such as an HMO) if it does so uniformly across the HCCA and provide adequate notice. In this event, it could not market such a policy in the State for five years.</p> <p>During the transition period, an insurer could deny enrollment to</p>

Mr. GREENWOOD. That is all, Mr. Chairman.

Thank you.

Mr. WAXMAN. Thank you very much, Mr. Greenwood.

Mr. Kreidler.

Mr. KREIDLER. Thank you, Mr. Chairman.

Kristine, it is indeed nice to see you here.

Kristine Gebbie and I go way back because we are both from the State of Washington, at least she was most recently from there.

Ms. GEBBIE. Other hearing rooms.

Mr. KREIDLER. That is true, many of those. In fact, for 2 years, as she was Secretary of the Department of Health, their first Secretary, and in that capacity we worked on health care reform, and she provided invaluable assistance to the commission, which I was a member of for 2 years, in drawing up health care reform which passed the State legislature last year, almost identical to the President's proposal for health care reform.

In your capacity as Secretary Department of Health, you undoubtedly came in contact with the State drug formulary. Let me just ask a question here that has to do with the coverage of new and expensive new prescription drugs which is a particular problem for people with AIDS. As you know, when AZT was approved, about half of the States, I believe we were one of them, had Medicaid programs with closed formularies, in fact, I know we were a closed formulary at that time, and it took almost 2 years for the 50 States to cover AZT. And during that time some AIDS patients simply had to go without the only approved drug for the condition.

Part of the delay was bureaucratic, and part of it was, I believe, a function of cost containment. How will you assure that formularies will keep pace with these innovative new treatments as they come along, particularly as it deals with AIDS research?

Ms. GEBBIE. The intent is that the formulary will cover effective drugs, that as new HIV drugs come on the market, one assumes that they would only be promoted as they are more effective. The more effective they are, the less hospitalization you see, the longer healthy periods you see, so that they become an appropriate thing to include. If they are excluded in any deliberate way, that is grounds for discrimination to be charged and action to be taken. The maintenance of timely treatment guidelines will be an essential part of that, and we have already started work to make sure HIV-related guidelines are there so that they are available to people to keep those formularies up in a timely manner.

Mr. KREIDLER. Thank you very much.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Kreidler.

Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman.

Ms. Gebbie, many people argue that so-called insurance market reform, eliminating preexisting conditions, portability, ensuring guaranteed renewability and the like, that that is enough to address the—our current health care concerns or health care crisis. Explain to me specifically how for those special populations why those reforms are not enough.

Ms. GEBBIE. Why simply reforming the insurance market—

Mr. BROWN. Yes, in terms of portability, in terms of preexisting—eliminating preexisting conditions and ensuring guaranteeability and the like.

Ms. GEBBIE. Well, the first part of the answer you already heard from Dr. Feder, that unless it is assured that everybody is always insured, you end up with openings that people with a condition such as HIV slip right through, and get out of a plan at a time when they most need to be there. They need assurances that the package of benefits is adequate: that it includes prescription drugs, outpatient care, and hospitalization benefits.

Under the array of benefits offered under insurance plans now, the packages are incomplete for many of the services most essential to helping someone with HIV stay healthy, stay working and stay functioning. And maybe I think Dr. Feder could add some additional points, too.

Ms. FEDER. I was just reminded of the case we had 1 or 2 years ago, in which a large employer who was not purchasing insurance, who was self-insured, essentially cut back their benefits for one single person. I believe the case was with HIV. But this illustrates that employers can at this time reduce their benefits for people with high-cost illnesses, as well as for all their employees.

So essentially the issue is: is the coverage there while you are working, is it there when you are not working, is it always there? Because often when you are sick, you are not working. The question is whether that coverage is always there.

Mr. BROWN. In your testimony, if I could shift gears for a minute, you discussed a number of public health service initiatives that are included in the President's plan, school-based clinics, health education, social support services, expansion of primary care services and others. The plan actually, as you know, provides no money for these programs, only an authorization of appropriations. With last year's budget bill freezing appropriations for 5 years, if we enact these, how do you propose that we pay for them?

Ms. GEBBIE. We are going to have to work very closely with you to assure that the funding for those is maintained as a part of the overall plan. Because they are an essential partnership with the personal coverage.

Mr. BROWN. Does the cost estimate for the President's plan include offsetting savings and existing public health programs, such as Ryan White clinics or family planning programs or community health centers?

Ms. GEBBIE. I can answer specifically for Ryan White because I and my staff have been working on that. Yes, there is a small offset based on what we now know is spent out of Ryan White to buy what will become covered services. It is our intention to continue the remainder of Ryan White available for the wrap-around services and supportive services that people with HIV infection need.

We have the opportunity with the Ryan White reauthorization coming up next year to look more closely at exactly how the two will come together to continue that wrap-around.

Mr. BROWN. How about in other programs, Ms. Feder?

Ms. FEDER. Essentially, the overall policy here, as Kristine has laid out, is to avoid paying twice for the same services. And we

have that, applied that approach across the board in developing the financing estimates for the program.

Mr. BROWN. OK.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you very much, Mr. Brown.

One of the most divisive issues in this country today has to do with illegal immigrants. And there are estimates of 3 and 4 million people living in this country who will not be eligible for coverage under the President's bill because they are not citizens and they are not residing permanently or legally in this country. A consequence of not covering illegal immigrants means a lot to those people involved and to certain areas of the country where there is a heavy concentration.

Later today we will hear from the National Council of La Raza, two elements of the President's bill, the denial of coverage to undocumented immigrants, plus the use of the Health Security Card, will in combination create an enormous threat to the civil rights of all Latinos in the United States, whether they are U.S. citizens or not.

As an alternative, they recommend, among other things, covering everyone who is legally working in the United States, covering all children and pregnant women, regardless of immigration status, allowing each State to decide whether to cover additional undocumented people, and issuing an identical Health Security Card to everyone with information as to who is not eligible encoded on the card. What are your reactions to these suggestions?

Ms. FEDER. Well, Mr. Chairman, I think that it is useful to reiterate what our thinking was in putting the proposal forward as we did. It is our belief that it is American citizens and legal residents who ought to be—and in the proposal are—entitled to the guarantees under the Health Security Act.

And in terms of addressing the legal residents, we took an approach that focused on people who do establish some—what is indicative of a permanency of residence here as opposed to a transitional status. And so we believe that we have appropriately covered the appropriate population.

We are also concerned, however, about the need to provide health services, and the needs of communities to provide health services, to non-eligible people who find themselves in those communities. And we have done that in a number of ways.

We have retained the coverage of emergency services under Medicaid. We have established a Vulnerable Population Adjustment Fund that provides assistance to hospitals in communities that do have particularly high numbers of people who are there illegally. And we have retained the support for public health programs that provide services without regard to citizenship. We believe we have most appropriately addressed that problem.

Furthermore, we have prohibitions on the use of Health Security Cards for any purpose other than that which they are intended, which is simply to identify a person's association with a plan.

Mr. WAXMAN. Take Los Angeles County. Los Angeles, of course, is one of the areas with a heavy concentration of undocumented aliens. In the L.A. County Hospital System, nearly two-thirds of the births in 1991, some 29,000, were to mothers who were undocu-

mented aliens. Now, they are going to get medical services for the delivery of their babies. And the county system is going to have to pay for it, even though it is the immigration at the Federal level and the failure to carry out our immigration policy, that has provided all these new patients for whom the county is now going to have to provide services. How can the county of L.A. or any other hospital absorb the costs of that under the Clinton program?

Ms. FEDER. I think that in the particular case that you mention, the emergency services under Medicaid could provide Federal assistance in that regard, as would the public health funding for the prenatal services that those women would need to have healthy babies.

As I indicated to you, we do believe that the measures that we have included provide support, but we are happy to work with you to address your concerns.

Mr. WAXMAN. We now provide emergency care for anybody who comes into a hospital emergency room, whether they are legally here or not, we provide natal care, and I gather prenatal care for women who are about to give birth to babies.

What about the whole thrust of this initiative, which is to try to keep people healthy? If they don't get access to primary care, they are going to end up in emergency rooms. Aren't we in effect condemning ourselves to higher costs for illegal undocumented aliens because we didn't give them earlier care?

Ms. FEDER. Well, what we are trying to do is establish a balance to address those kinds of needs without creating a situation in which some have expressed concern, that would be inviting people into the country in order to obtain medical services. And I think what you are highlighting is the importance of the investment in the public health service infrastructure to which we are committed in the President's plan, in order to ensure the availability of those services.

Mr. WAXMAN. Thank you very much.

Mr. Sharp, did you want to ask some questions?

Mr. SHARP. Thank you very much, Mr. Chairman.

I appreciate you letting me sit in with your committee, but I will hold my questions. You have a lot of witnesses today.

Mr. WAXMAN. We want to thank you both very much for your presentation to us this morning. We look forward to working with you on this legislation.

Ms. GEBBIE. Thank you.

Ms. FEDER. Thank you, Mr. Chairman.

Mr. WAXMAN. Before we call on our next witnesses, I want to call on Mr. Bliley as the ranking member, Republican member of this subcommittee, in order to give him an opportunity to present his opening statement for this hearing.

Mr. Bliley.

Mr. BLILEY. Thank you, Mr. Chairman. I apologize for being late, but traffic this morning was hopeless.

Today we resume our hearings on the President's Health Security Act. We will hear testimony from many different groups who represent special populations with unique health care needs. Some of today's witnesses represent the disabled or those afflicted with life-threatening diseases. These are individuals who generally ben-

efit from the American health care system which provides the highest quality of care in the world.

In this regard, I would again like to point to the Consumer Price Index cap in the Clinton health care plan. We should again recall that a CPI target would create a tighter spending control system than that of any other western nation.

This is a point I first addressed to Mrs. Clinton at our hearing on September 28th. When I used this chart comparing international growth rates in health care spending, I pointed out to her that in the 1985-1991 time period, the British nationalized health care system grew at an annualized per capita rate of 3.84 percent above inflation.

The Canadian single-payer system grew at an annualized per capita rate of 3.58 percent above inflation. No nationalized estimate has come close in limiting spending to the CPI. And in the case of Britain and Canada, we are talking about systems that explicitly ration health care to the sick and elderly.

For example, elderly patients in Britain are routinely denied high-tech treatments such as kidney transplants or heart bypass operations. And now we can look to our Canadian neighbors to see how the global budget affects health care. As you will momentarily see in this newscast from Ontario, the government ran out of money several days before Christmas and had to close their hospitals except for emergency care for several weeks. Many Ontario hospitals closed one half of their beds, shut down AIDS and TB clinics, and postponed all elective surgeries for a several week period.

Let us now closely view this news report. We will be looking at our own unfortunate future under the Clinton health care rationing plan.

[Videotape was played.]

Mr. BLILEY. We asked about this shutdown, the President of Mount Sinai Hospital in Toronto stated that this is not about health care, this is about the deficit. One example of treatments that were affected by the shutdown is described in The Washington Post by an orthopedic surgeon named Robert Bell. He stated that three of his bone cancer patients had to be sent elsewhere for 2 weeks during the shutdown. He states that, quote: "The delay will not reduce the patient's life-span, but it will extend the duration of their pain. Their discomfort level has been increased by weeks."

Dr. Bell, who practiced medicine for 2 years in Boston, further stated: "If you said to an American patient, we are going to delay your surgery for 2 weeks because of costs that are involved, they would never accept it." Well, Doctor, I sincerely hope you are right.

The question that the administration cannot answer concerning their "Health Care Rationing Act" is how the administration's plan is going to limit health care expenditures to zero real growth, when even national systems that ration health care have not remotely approached these spending limits. The Canadian system, which has grown at 3.58 percent above the CPI, must close its hospital doors.

What is in store for Americans when we will be forced to grow significantly slower? Price controls and global budgets must lead to health care rationing, particularly for the elderly and the chronically ill.

Let us not forget that after the Bush administration rejected the Oregon health care rationing experiment, President Clinton approved it. And what is Oregon's standard of medically necessary care for the severely ill? Unfortunately, Oregon's standard of appropriate care for needy residents exclude high-tech, life-sustaining procedures for advanced AIDS cases, as well as extremely premature babies and advanced cases of certain cancers.

The Oregon rationing experiment and the Canadian global budget which shuts down hospitals when the money runs out, shows us clearly the direct impact of price controls on health care. These examples also point to our future under the President's health care plan, and I am certain that for this reason Americans will reject the "Clinton Health Care Rationing Act."

Thank you, Mr. Chairman. I apologize for the delay.

Mr. WAXMAN. Thank you, Mr. Bliley.

Our next panel consists of advocates for populations that move from shelter to shelter, from family to family, from city to city and from State to State, even from country to country. They each face nonfinancial barriers to access.

Joel Diringer is with California Rural Legal Assistance, and will discuss the impact of the President's plan on migrant workers and their families. Dr. Neal Halfon is Associate Professor of Pediatric and Public Health at UCLA. He will discuss the impact of the President's plan on foster children. Dr. Irwin Redlener is President of the Children's Health Fund, a private initiative for homeless children. Dr. Laurance Nickey is the Director of the El Paso City County Health Department and will discuss the impact of the President's plan on residents of the U.S.-Mexico border.

I would like to ask our witnesses to come forward.

We are pleased to welcome you to our hearing today. Without objection, your prepared statements will be in the record in full.

What we would like to ask each of you to do is to limit the oral presentation to no more than 5 minutes.

Mr. Diringer, why don't we start with you.

There is a button on the base, please push it forward.

STATEMENTS OF JOEL DIRINGER, ATTORNEY, CALIFORNIA RURAL LEGAL ASSISTANCE; NEAL HALFON, ASSOCIATE PROFESSOR OF PEDIATRIC AND PUBLIC HEALTH, UNIVERSITY OF CALIFORNIA; IRWIN REDLENER, PRESIDENT, CHILDREN'S HEALTH FUND; AND LAURANCE N. NICKEY, CHAIRMAN, COUNCIL OF PUBLIC HEALTH, TEXAS MEDICAL ASSOCIATION

Mr. DIRINGER. Thank you, Chairman Waxman, and members of the committee. My name is Joel Diringer. I am an attorney and health policy advocate with California Rural Legal Assistance.

I apologize for the change in scheduling, but Delores Huerta the Vice President of the United Farm Workers, was to have attended today and unfortunately her plane from California was canceled.

I appreciate the opportunity to testify on behalf of the nearly 4 million migrant and seasonal farm workers who lack even the basic access to health care. A recent UCLA study found that over two-thirds of Latino farm workers are uninsured. This is four times the national average and more than any other group.

The GAO reports that the existing migrant health center clinics receive only 15 percent of the funding necessary to meet the needs. Medicaid, the supposed safety net for poor Americans, fails farm workers miserably.

Let me give you an example. Just last week I was at a meeting with our farm worker advisory committee in rural Paso Robles, Calif., where the local rural health clinic had proposed expanding their clinic to meet needs. Unfortunately, they were only able to offer Medicaid services or full pay. Basically, the farm workers yawned. They can't get Medicaid because they work or they don't have children. They just aren't part of the system. For those who do get Medicaid, there are enormous problems in that there is a lack of interstate compacts between the States with the three largest migrant populations, California, Texas, and Florida.

An example of this is an infant, Maria Velasquez, from Penitas, Tex., who was left for 5 extra months in a neonatal intensive care unit in Michigan where her parents were working for the summer. They couldn't arrange for her transfer back to Texas because the State Medicaid programs couldn't coordinate coverage. Incredibly, the Michigan hospital was trying to get foster—the child into foster care to get her out of the hospital, solely because the Texas Medicaid program couldn't ensure coverage.

Farm workers toil in the Nation's most dangerous occupation. There are 22,000 disabling injuries in California alone annually. Forty farm workers die on the job every year there. There is also an outbreak epidemic in tuberculosis, a higher and disproportionate incidence of AIDS, diabetes, high blood pressure. Many of these could be prevented with access to screening and prevention programs. They don't exist for farm workers.

The most shocking problem is that farm workers go hungry. A 1990 study found that one-third of farm worker families in California's most abundant and productive agricultural valleys face severe hunger.

Now, the Clinton proposal or national health reform has an incredible potential to ensure coverage for farm workers, in universality aspects and its affordability aspects. However, it also has the great potential to leave farm workers out of the plan, as happened in Washington State last year when they enacted their nearly universal plan and excluded farm workers and shifted that to a commission to study agricultural workers.

The first issue under the Clinton plan is the portability issue, whether coverage will be available in all regions where farm workers exist. Unfortunately, the plan is based upon regional-based managed care plans, as being the lower-cost plans, and probably the only ones that farm workers can afford. While out of their area, while out of their regional alliance area, farm workers will only be entitled to emergency or urgent care, or be forced to pay the higher cost sharing of 20 percent.

A third option is to buy the most expensive fee-for-service plans, which will be basically unavailable. Farm workers will continue to lack primary and preventive care, waiting for conditions to be more severe and more expensive to treat.

Another issue in the current plan is cost. The copays under the Clinton plan are the same for all. The millionaire agribusiness cor-

porate director will pay the same copays as the impoverished field hand who picks the crops. The subsidy system is only available for those on AFDC or SSI, and not for the working poor, people at the same income or lower levels will be forced to pay higher.

The projected premium costs will also be very high, especially given the ongoing and pervasive practices of calling farm workers "independent contractors." Cultural and linguistic services are not guaranteed under the plan. Translation is a State option, not a mandatory service.

There are also no Federal minimum standards for access and quality, no travel and distance standards, no transportation and outreach services. Migrant health centers are at risk for their funding despite some short-term preferential contracting, and may not exist. Basically because it is an employment-based plan in an industry that has pervasive labor abuses in terms of hiring farm labor contractors with shoddy business practices who don't report and pay social security premiums, and also the fact that farm workers are often shifted into independent contractor status, albeit illegally, the plan will not guarantee coverage at all; and it is because of its employment basis.

There will also be a shell game going on on the part-time issue. Now, to be a part-timer eligible employee, you have to work for the same employer 40 hours per month. As migrant workers move from job to job or perhaps even work on the same job, there will be a shell game of supposedly different but in reality interlocking employers who act as the employer and avoid the minimum hour requirements. These games are easy in an industry where labor supply exceeds job availability and the enforcement of labor laws is lax.

Mr. WAXMAN. Thank you very much, Mr. Diringer, for your testimony.

[Testimony resumes on p. 48.]

[The prepared statement of Mr. Diringer follows:]

STATEMENT OF JOEL DIRINGER

Chairman Waxman and members of the Committee:

My name is Joel Diringer. I am an attorney and health policy advocate with California Rural Legal Assistance. I am also director of the Rural Health Advocacy Institute, a joint project of CRLA and the CRLA Foundation.

On behalf of the nation's 4 million migrant and seasonal farmworkers who do the backbreaking work of planting, tending, harvesting, and packaging our produce, I appreciate the opportunity to address your committee. The voices of farmworker families who quietly provide us with our daily food have been largely absent from the national health care debate, drowned out by the cacophony of providers, insurers, businesses, and lobbyists. Yet, the health care needs of migrant and seasonal farmworkers are immense given their historic disenfranchisement. A system that promises universal access must be measured by its ability to provide health care to the most marginalized in our society.

Migrant and seasonal farmworkers lack even basic access to health care. A UCLA study team recently found that a startling 65% of Latino farmworkers are uninsured. This is over 4 times the national average. Even fewer of their dependents are insured. The General Accounting Office reports that existing rural and migrant health clinics receive only enough funds to meet 15% of the health care need. Public hospitals, particularly in rural counties, have closed at alarming rates. In counties where public facilities do exist, they are usually located in urban centers,

far from where farmworkers live and work. Even "mainstream" providers shun the rural areas.

Medicaid, the supposed health insurance safety net for poor Americans fails farmworkers miserably. They are generally excluded from Medicaid precisely because they work. Earlier this month I attended a meeting of our farmworker advisory committee in the rural town of Paso Robles, California. A key item on the agenda was the proposed expansion of a rural health clinic into their area. The health clinic doctor explained that they could take all Medicaid recipients for free, but they would have to charge full fee for private pay farmworkers. The doctor was greeted with silence. Why? Because hardly any of the farmworker families had Medicaid; they couldn't get it. They don't benefit from the federal programs; they pay out of their pockets or forego care.

For the few migrant farmworker families who do get Medicaid, services are disjointed and sporadic. The three states with the most migrant farmworkers - California, Texas, and Florida -- do not have interstate agreements with other states.

Take, for example, the case of infant Maria Velasquez, the daughter of migrant farmworkers from Penitas, Texas. Maria was separated from her parents in a Michigan neonatal intensive care unit for five extra months before being transferred home to a Texas facility. The reason - Texas couldn't coordinate Maria's Medicaid coverage with Michigan. It was only through the intervention of a legal services attorney that the arrangements

were completed. Even more astonishing, the hospital in Michigan was seeking to place Maria in foster care in order to discharge her from the hospital. Transportability of coverage is obviously critically important for migrant families.

Farmworkers also toil in nation's most dangerous occupation. Farmworkers and their families face risks from accidents, pesticide-related illness, on the job injuries, respiratory conditions, reproductive health problems, climate-caused illnesses, and communicable diseases. There were over 22,000 work related disabling injuries to farmworkers in California alone in 1990; each year 40 California farmworkers die on the job. Reproductive hazards are particularly alarming since the agricultural work force is predominantly young, and over a quarter are women.

Farmworkers and their families are also in daily contact with the deadly toxins contained in pesticides. Nationally, nearly 4 million farmworkers are exposed to pesticides. Their children are exposed by drift, by living and playing near the fields, by drinking the water, and by hugging their parents who may have residue on their clothes. Childhood cancer clusters have been identified in several California Central Valley farmworker towns, including McFarland and Earlimart. These health threats, including the long-term cancer dangers of low-level pesticide exposure, must be confronted in a national health plan that stresses prevention.

In addition to living in poverty, working in low-wage and dangerous occupations, and having fewer health services, the Latino farmworker is also in poorer health. Latinos suffer disproportionately higher incidence of tuberculosis, AIDS, diabetes, high blood pressure, kidney disease, and some cancers.

Much of the suffering caused by these diseases could be prevented. With proper treatment, almost two-thirds of the diabetes-related blindness and amputations, and half of the kidney failure, could be prevented, if appropriate screening and treatment is available. Unfortunately, access to screening is very limited for the rural Latino population.

Farmworker communities face a number of additional health risks. Farm labor housing is abysmal. Many homes lack septic tanks or running water. Lead paint in what poor housing is available is a particular risk for children. Rural, low-income and minority residents suffer disproportionately from water and air pollution caused by the excessive use of agricultural chemicals. They're also more likely to have a major toxic waste facility in their communities.

The most shocking of all the health problems is that the families who toil in our abundant fields go hungry. A 1990 study found that more a third of the farmworker families surveyed in California's four most agriculturally productive counties faced severe hunger. They skimp on food, skip meals and run out food money on a regular basis. Their children go to school hungry, and suffer educationally. Our health system must provide more.

Since farm work is often seasonal, periodic, part-time, and requires working for a number of different employers in a years' time, any employer-based or employer-financed plan will have problems. Given agribusiness's creative use of deceptive practices such as the hiring of farm labor contractors or calling farmworkers "independent contractors" to avoid employer responsibilities, the task of ensuring health insurance will be even more daunting.

The use of unscrupulous farm labor contractors was recently documented in testimony before the California Assembly Revenue and Tax Committee. Abused farmworkers testified that they were paid subminimum wage, and that the labor contractors deducted, but did not forward, the social security payments to the IRS. According to the Assembly staff briefing report, the uncollected tax revenue costs the State of California as much as \$111 million annually.

What we have seen here is a continued legacy of poor health among farmworkers and rural populations, with diminishing access to health care. National health reform has the potential to ease the pain of those who have been left out of the health care system. It also has the potential to leave farmworkers out of the plan. Witness Washington state's Health Reform Act which, at the growers' behest, specifically excluded farmworkers and referred the issue of their coverage to a commission. How has the President's proposal addressed the concerns of migrant and

seasonal farmworkers and their families? Unfortunately, while it promises universal access to health care, the reality is that farmworkers may continue to be denied the health care they need.

Portability of coverage

The benefits provided by the health plans may not be available to farmworkers. For migrant families, a the lower cost geographic based managed care plans will not work. Depending on the plan selected, a farmworker may be limited to affordable coverage only for emergency or urgent care while out of the health plan's service area. Services received "out-of-network" will be at a much higher price than many farmworkers can afford.

Migrant families will not get the primary and preventive care that the plan supposedly encourages. In the end, the workers will wait until conditions are more serious and more expensive before seeking care.

Cost

Cost is another serious issue confronting farmworker families. The majority of farmworkers live at or below the poverty level, in spite of the fact that all able-bodied members of the family work whenever possible. Yet, the co-pays under the President's plan are the same for all - the millionaire agribusiness corporate directors pay the same as the impoverished field hands who pick the crops. The subsidy system for co-pays envisioned by the President's bill provides for those on AFDC and SSI, but does nothing for the working poor. Co-payments should

be scaled down to fit low-income budgets, regardless of welfare or work status.

The projected premium costs will also prove daunting for farmworker families. An on-going and pervasive practice used by many agricultural employers is to call migrant and seasonal farmworkers "independent contractors". Unless challenged on an individual basis by a farmworker with the aid of counsel, this illegal practice will make the farmworker responsible not only for the 20% family share of the premium, but also the 80% employer share. For a farmworker family of four with an adjusted gross income of \$20,000, these premiums will cost over \$2000 a year - more than 10% of their income.

Cultural and linguistic competence

A universal health plan also needs a requirement that the services be culturally and linguistically appropriate. Many farmworker families speak Spanish as their first or only language. There are also a large number of recent Latino immigrants - the "indigenas" - for whom even Spanish is a second language. Not to mention the farmworkers of Asian and Caribbean descent who speak no English.

Yet, the Clinton plan does not mandate that services be culturally and linguistically appropriate. Translation services are a state option, not a national covered benefit. Varied state plans with differing benefits - as we currently see in Medicaid - is a particular problem for migrant populations. Moreover, there is no requirement that alliances and health plans

make consumer information available in languages other than English.

Access

Where will farmworkers get care under the Clinton plan? In theory, their chosen health plan will be required to provide services. Yet, there are no federal minimum standards for access and quality. While the bill contemplates federal standards for capital and marketing, the National Health Board is given no authority to set minimum requirements that health plans must satisfy with respect to access and quality. There are no travel time or distance standards which would benefit rural populations. There are no guarantees that a provider will exist close to a farmworker's home, and be available at accessible hours. There are also no requirements for transportation and outreach services.

The traditional safety net for migrant families - the migrant health centers - are at risk under the plan. While they receive some preferential contracting rights under the President's proposal, these last only for five years. Current funding is already insufficient to meet 85% of the need, and future funding appropriations are not guaranteed.

Employment issues

The biggest problem with the Clinton proposal is that it is an employment-based plan. Growers currently have every incentive to avoid basic employee protections such as workers compensation, unemployment insurance, social security, child labor and

pesticide laws. They do this through the hiring of farm-labor contractors and calling farmworkers "independent contractors." They thus hope to avoid any employer responsibility, while maximizing production and income.

These problems will only be exacerbated by a system that imposes an additional 7.9% cost on an employer's payroll. Growers will increase the use of farm-labor contractors, many of whom are unscrupulous and fail to withhold or report required employee deductions. This results in increased burdens for the workers, monetary loss for the public benefit systems, and denial of important benefits for farmworkers.

Growers and labor contractors will also adroitly circumvent the requirements that qualify a worker as an employee eligible for health benefits if he or she works 40 hours per month. They will play a "shell game" of supposedly different, but in reality interlocking employers to avoid the minimum hour requirements. Such games are easy in an industry where labor supply exceeds labor demand, and enforcement of labor laws is lax. In California alone, the Employment Development Department estimates that there are 800,000 farmworkers for 350,000 jobs.

Growers will also find new ways to call farmworkers "independent contractors" thus shifting all employer responsibilities on the farmworker.

In sum, a reformed health system that is employment-based will fail farmworkers. With the historic disparities in power between farm labor and the growers, and the woeful failure of

federal and state agencies to enforce current employee, the Clinton plan will not ease the pain of migrant farmworker families.

What is called for is a truly universal health plan that is national in scope. It must be funded outside of the employment context. Health services must be delivered wherever a migrant family is, at a cost which is truly affordable to farmworkers. To do otherwise will continue to deny basic health services to those who toil in the fields. Your committee must give priority to what will work for the hands that feed us.

Thank you.

Labor Fraud on The Farm

By John Jacobs

A dramatic Assembly committee hearing on the underground economy in California agriculture elicited some gripping testimony from Mexican farm workers earlier this month. They talked about how unscrupulous farm labor contractors compelled them to break the law and to lie about their employment so that the contractors could pay them sub-minimum wages and otherwise exploit them.

Testifying in Spanish and asking not to be photographed or televised for fear of reprisals, these workers described to the Assembly Revenue and Taxation Committee how they were paid low wages under the table and under a phony name. At the same time, they were told to apply for unemployment insurance using their real name. Failure to go along meant no work.

This ruse and others like it — which United Farm Workers of America President Arturo Rodriguez described as "rampant" throughout the seasonal agriculture industry — permit contractors to evade paying taxes and forces workers to lie to get government funds to supplement the \$20 a day or so they are paid. In addition, the state loses millions of dollars in uncollected tax revenues, as much as \$111 million, according to a committee staff briefing report.

One veteran of 27 years of working in the fields described how she was promised an hourly wage of \$5.50. After working eight-hour days for a week in the Coachella Valley, she was paid \$71. Her check stub recorded that she was paid for just a few hours a day, a fiction that allowed the contractor to pretend that he paid minimum wage. When she complained, a forewoman told her that she and her husband should work under the same Social Security number and get unemployment with the other one. "That should be enough," the forewoman said. They refused and had to look for work elsewhere.

What these stories underscore, says Don Villarejo, executive director of the California Institute for Rural Studies, are two related phenomena. First is what he calls the "Mexicanization" of California agriculture. Some 92 percent of farm workers are now foreign born, 89 percent of them in Mexico.

Second, the nature of labor-intensive seasonal agriculture has changed in recent years, and new waves of Mexican immigrants have replaced Mexican Americans in the fields. As growers have sought to absolve themselves of any legal responsibilities for providing for the health and safety of their workers, they have turned to farm labor contractors to hustle up farm laborers. Their use of these contractors has doubled in the last 10 years, Villarejo said.

It is duplicitous to now make these immigrants political punching bags, as so many California politicians have done, while ignoring those legal immigrants and U.S. citizens who cheat them, abuse the system and profit from their labor.

"What strikes me," said Sacramento Assemblyman Phil Isenberg, a member of the committee who has long been interested in farm worker issues, "is the hypocrisy. We condemn and blame illegal immigrants for all the problems of our society and then condone and encourage illegal immigrants to work in agriculture. It doesn't take a genius to figure out that agriculture makes its money by having a never-ending supply of people willing to work for subminimum wages."

Isenberg has again introduced legislation, AB 90, which would make the owners of agricultural property legally responsible for the wages, hours and working conditions of their workers, whether or not they use farm-labor contractors. A similar bill died last year.

With so many Mexican workers in the fields, it's hardly surprising they bring their culture and values with them, said Villarejo, including "la mordida," or "the bite." Half the people who work under this system of labor contractors make cash payments of up to \$5 a day for rides to the job — usually as a condition of employment. The foreman may find work for a new farm worker as long as the farm worker pays.

Communities of farm workers are often extended families or people from the same Mexican villages. Those who come from Jaripo in Michoacan know to go to Stockton, where a network awaits them. Those who migrate from Oaxocha go to Madera.

In theory, the system works for everyone. Newly arrived immigrants find their place in the network. Labor contractors get

their fees from the growers and deliver the work crews, and growers get the seasonal workers.

What's wrong, aside from the revenue loss, is that the worker may go to collect unemployment insurance and find that his name was never officially recorded — even though his paycheck may have reflected the "deductions" — and he's out of luck. Or he gets injured on the job and there's no disability pay.

One way to begin to fix some of these problems is to force growers to come out into the open and accept responsibility for their workers, rather than hide legally behind their labor contractors. Isenberg's bill would do that. Another is to seriously step up enforcement of labor violations, which is beginning to happen.

John Jacobs is political editor of the McClatchy News Service.

The Sacramento Bee

DECEMBER 9, 1993

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Farm labor tax cheating costs millions, critics say

By Marcos Bretón
Bee Staff Writer

While California struggles through recession, the state is losing millions of tax dollars every year through lawlessness and cheating in the \$18 billion-a-year agricultural industry, an Assembly committee was told Wednesday.

Farm workers, the head of the United Farm Workers union, academics and other experts said falsified documents, shadowy labor contractors and compliant growers are behind a startling figure: an estimated \$111 million in annual income not being collected by the state from the agricultural industry.

"Growers frequently point to all the laws in California that have been passed to protect farm workers. ... But all the laws mean nothing when they are regularly and systematically ignored," said UFW President Arturo Rodriguez.

"It is our experience that millions of dollars deducted from farm workers' checks never get forwarded to state and federal tax agencies," he said.

Wednesday's hearing was organized by the Assembly Committee on Revenue and Taxation to put into focus just how much in potential revenue from California agriculture is instead sliding into the "underground economy."

According to the Employment Development Department, agriculture is one of the state's largest employers, with close to 900,000 workers on the job at some point during the year.

Growers' representatives at the hearing acknowledged the problem of unscrupulous wage practices but said it was being blown out of proportion by other speakers at the hearing.

Robyn Black, owner of Anderson Farms in Fresno County, said that neither she nor the farmers she knows are knowingly breaking the law. "I think the bad actors are in the minority of farmers," Black said.

Some committee members also expressed shock at the testimony of some witnesses. "This is the first I've ever heard of some of these allegations," said Assemblyman Ross Johnson, R-Fullerton.

But according to farm workers and others testifying Wednesday, cheating in farm wages has been occurring for years.

"The big-ticket cost of agricultural exploitation is in wages," said Mark Schacht, a lawyer for California Rural Legal Assistance.

Most speakers pinned the blame on farm labor contractors who are commissioned by growers to go out and find workers for the harvests. According to Schacht and others, these contractors often operate without a license and will pay substandard wages in cash, rip off state and federal deductions from the wages, and fraudulently double up or triple up workers on one Social Security number.

Martin Cruz, a farm worker from Fresno County, told committee members that he has known contractors who have forced employees to work under false Social Security numbers and have encouraged them to fraudulently collect unemployment insurance at the same time. "Double dipping," as Rodriguez called it.

Karl Grossenbacher, deputy director of EDD, said that because these contractors have no assets, they are "judgment proof."

There were no contractors at Wednesday's hearing, but they were singled by farm workers and growers alike as a major problem.

Assemblyman Phil Isenberg, D-Sacramento, criticized the growers' immunity from abuses caused by contractors they hire. "If you remove responsibilities from farmer and property owner, it is easier for problems to happen," Isenberg said.

"And when a contractor cheats a worker, the grower says, 'Geez, that's not my problem.' Well, I understand that that may be legal, but it's not moral."

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Mr. WAXMAN. Dr. Halfon.

STATEMENT OF NEAL HALFON

Mr. HALFON. Congressman Waxman, members of the committee, my name is Neal Halfon. I am an Associate Professor of Pediatrics and Public Health at UCLA. The last 10 years I have been providing services for children in foster care and designing child-friendly delivery systems to address their special needs.

Many of these children have been the unfortunate victims of abuse and neglect and/or in double or triple jeopardy due to a combination of chronic medical conditions, emotional and developmental problems, and other disabilities. Unfortunately, all too often they continue to experience neglect at the hands of an inadequate health and social welfare system.

President Clinton's plan goes a long way to improve access for children in foster care, yet there is still a number of problems that need to be addressed. Children in foster care are a diverse group of children. They include children in foster homes, but also children in youth and group homes, in special placement centers, as well as children and special needs adoptions and some children in the juvenile justice system.

The population of children in foster care is increasing. At the end of the fiscal year 1993, there were approximately 460,000 children in foster care in the United States. With more than 659,000 children served by the system that year.

I think the essential question is, what makes children in foster care particularly vulnerable and why do they need special considerations under the health care plan? And there are basically seven reasons: First is that 30 to 40 percent of children in foster care have chronic medical problems, including higher rates of developmental problems, HIV infections, neurological disabilities, and common illnesses like asthma; 60 to 80 percent of children have chronic persistent and debilitating mental health problems.

While all children are developmentally vulnerable, children in foster care are even more so, due to frequent moves and transition that cause them to stop and restart their lives over and over again.

The fourth is the issue of dependency. While all children are dependent on both their families and other social institutions, children in foster care are completely dependent on public services to meet all their human needs.

Fifth is the issue of complexity. The multiple intertwining health and social needs require a higher intensity and more coordinated services that are not easily provided by most basic medical care plans.

The sixth issue is inadequate coverage. Most children in foster care currently are eligible for Medicaid through a complicated patchwork of eligibility criteria. However, Medicaid itself has proved to be a significant access barrier for many children in foster care. And over the last 10 years there has been seven major class action suits around the country basically because children in foster care have not been able to receive the health services they need.

The last issue that makes them particularly vulnerable is the issue of cost. Providing care to children in foster care is costly due to their larger number of problems and more complex issues. Yet,

there are incredible inadequacies and multiple inefficiencies in the current delivery system that exacerbate cost problems and waste resources.

When we—when crucial health services are not provided, for example, when a child's developmental delay is not adequately assessed, we end up paying for that in special education costs down the line. The same thing goes for mental health problems that are not addressed in foster children. We end up paying for that in the juvenile justice and prison systems. The real tragedy is for both children in foster care and for the society as a whole, that much of what these children suffer from can be prevented or ameliorated.

While the President's plan goes a long way towards giving these children what they need, coverage still under the President's plan is not adequate. Performance standards for quality and legal safeguards are also not adequate. Under the President's plan, all children in foster care will be eligible for a comprehensive benefit package. However, given their multiple intertwining health problems, children in foster care require more than what is in the so-called "comprehensive health package," especially to address their mental health development, rehabilitation and case management needs.

The President's plan does include a supplemental benefit package, but the eligibility for these enhanced benefits would be based on Medicaid-, SSI- and AFDC-related criteria that are largely irrelevant for this group of children. While many of the children in foster care would receive the supplemental benefit, there are a large number who would not.

I would recommend for simplicity's sake and for efficiency's sake, that all children in out-of-home care should be eligible for enhanced benefits that can address their special needs. All the benefits in the world would not mean anything unless there is an appropriate delivery systems to provide them.

In order to improve the efficiency and effectiveness of the delivery system, children in foster care need customized delivery systems. Not generic managed care plans. It is clear to me in my 10 years of experience of taking care of these children, that even the best managed care plans, like the Kaiser HMO's in California, do not do an adequate job of addressing these children's needs. While these children might receive basic medical care services and a good managed care plan, many needs go unmet. Essential services are often needlessly delayed with disastrous consequences.

What we end up doing is adding to the parental neglect, we add on system neglect by our health system. In several cites around the country, special regionalized foster health care plans have been organized to remove system barriers and improve efficiency of services. It should be noted that most of these programs have been developed using Medicaid, SDT and other funds blended together to provide innovative services. It is not clear that in the future those kinds of programs, those kinds of innovations, will be able to continue.

Other special considerations are essential. Because children are often moved from placement to placement, special attention must be paid for providing immediate eligibility as soon as a child is removed from their home, guaranteeing portability of coverage when

placements change, and minimizing and simplifying cost-sharing requirements by eliminating copayments and providing premium subsidies so that additional burdens are not placed on child welfare system or on foster parents.

Congress must also ensure that necessary protections for children in foster care are included in the legislation or provisions made for how these safeguards will be developed by the responsible Federal agency, the National Health Board, States, health alliances and the health plan. And I provided in my written testimony greater detail on each one of these issues.

I just want to close by saying that when my colleagues and I conducted our analysis, and you will see from my written testimony that just to wade through the stuff in the foster care area took myself, a physician, two lawyers and a social worker just to sort of tear that all apart to know what they were getting now and what would happen under the new plan, because it is so incredibly complex. We also did one other thing; we took a pediatric standard of coverage in order to adequately assess three important things that are different for children than are for adults. That is the dependency issues, the developmental vulnerability issues, and the fact that children have special health care problems that aren't the same as adults. And foster kids represent the extreme of dependency, of developmental vulnerability, and of special health care problems.

In closing, I would like to suggest that Congress consider using the pediatric standard of coverage as a way of assessing how well it is attending the special health care needs of children and especially those who are the most vulnerable, like children in foster care. Moreover, such a standard of coverage should be included explicitly in the plan to ensure that the special needs of all children and especially those in foster care who are most vulnerable are appropriately addressed.

Mr. WAXMAN. Thank you very much, Dr. Halfon.

[Testimony resumes on p. 64.]

[The prepared statement of Mr. Halfon follows:]

National Health Care Reform, Medicaid, and Children in Foster Care

by

Neal Halfon, M.D., M.P.H.

Abigail English, J.D.

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Madelyn DeWoody, M.S.W., J.D.

The unique health, legal, and social status of children in foster care* pose particular problems for the designers of any kind of health plan. Because many children in out-of-home care are highly mobile, move from family to family, and from one geographic locale to another, the context of their lives challenges the assumptions that health insurance is based upon. This article attempts to highlight current access to health care services for this group of children, how the President's proposed Health Security Act would affect the delivery of health services, and what special considerations are necessary to meet the needs of this particular group of children's needs. We have focused on the President's plan partially because it provides the greatest amount of detail, and because the President's plan has the greatest likelihood of doing the most to improve the availability of appropriate health services for children in general, and children in foster care in particular**. The analysis printed here is based upon the version of the Health Security Act that was introduced in Congress by members of the House and Senate on November 22, 1993. This most recent version of the Health Security Act has incorporated changes that greatly improve the extent of coverage and other considerations for children in foster care compared to earlier drafts of the plan.

Studies have documented that while children in foster care experience high rates of serious health problems, they also face significant obstacles in their access to essential health care services. Although professional organizations such as the American Academy of Pediatrics and the Child Welfare League of America have developed excellent standards for health care services for children in foster care, the actual delivery of health care services to this needy population falls far short of these standards. The reasons for this failure relate to both the *financing of services* and the *organization of care*. President Clinton's proposed American Health Security Act of 1993 (as introduced in Congress on November 22, 1993) would have a major impact on the accessibility of health care services for children in foster care. In a number of important respects, the proposed plan would improve access but in other critical areas it would limit essential care.

* Generally "foster care" and "out-of-home care" are used in this article interchangeably to refer to children living in family foster homes, group homes, or residential treatment centers.

** While this article focuses on the strengths and weakness of the President's health care reform plan, most other plans that have been introduced by Congress, up to this point, have fallen even further short of addressing the health needs of vulnerable children.

Health Care Access for Children in Foster Care Under Current Law

Who are the children in foster care?

The population of children in foster care is growing rapidly. There were an estimated 460,00 children in foster care at the end of fiscal year 1993, with more than 659,000 served by the system that year. In the wake of escalating and persistent poverty, family violence, mental illness, and the drug epidemic, the number of children in foster care has been increasing nationwide since 1985. By 1995, it is projected that 500,000 to 600,000 children will be in foster care. The vast majority of these children live in family foster homes (70%), and the remainder are in group homes, residential treatment centers, or institutional settings.

What are the health care needs of children in foster care?

Children in foster care have high rates of serious health problems. Several studies have documented that children in foster care have high rates of chronic medical problems that require ongoing treatment. Approximately 60% of children in foster care have moderate to severe mental health problems. Children in foster care also experience high rates (40%) of physical health problems (e.g. asthma, growth disorders, neurological abnormalities). The high frequency of health and mental health problems is a result of the children's poor health prior to placement, the effects of abuse and neglect, the effects of separation and frequent moves, and the lack of access to appropriate health and mental health services. A particular concern is the increasing number of infants entering care with multiple health and developmental needs due in large part to maternal drug use and prenatal exposure.

Children in foster care require a broad range of health care services. Given the high levels of need, children in foster care require access to a full range of developmental and mental health services, habilitative, and rehabilitative services. For many infants and toddlers, services are most appropriately delivered in the foster home. Short-term mental health interventions involving foster parents can help maintain children in foster homes, reduce foster parent turnover, and decrease the probability that a child will need costlier longer term psychotherapy, special education services, or even inpatient treatment. The availability of a comprehensive benefit package with a sufficient range of preventive services and community-based treatment services can potentially generate cross-system savings.

How are the health care needs of children in foster care met?

The process of delivering appropriate health care to children in foster care is complex. The complexity of delivering health care services to children in foster care includes: the gathering of health information from the birth parents, past health care providers, foster parents, social workers, and schools; assessing intertwining medical, emotional, and developmental needs; and providing case management and coordination of services among multiple providers.

Most children in foster care are currently eligible for Medicaid. The majority of children in foster care throughout the United States are covered by the Medicaid program. Nationally, about 50% of the children placed in foster care were previously AFDC eligible and, therefore, are eligible for federal foster care payments under Title IV-E of the Social Security Act. Their title IV-E eligibility automatically confers eligibility for Medicaid as well. Children with special needs who meet federal IV-E eligibility requirements and are adopted, retain their Medicaid eligibility after they leave the foster care system. Many states also have elected to cover under Medicaid other children in foster care, who are not IV-E eligible children, through the "Ribicoff" provision of the Medicaid statute (Section 1905a(i) of the Social Security Act). In reality, a number of states automatically provide Medicaid to all children in foster care just as they do for children who are federally IV-E eligible. However, Medicaid eligibility and coverage for children in foster care does vary from state to state.

Medicaid eligible children in foster care are entitled to EPSDT services. Children in foster care who are eligible for Medicaid are entitled to the full range of screening, diagnosis, and treatment services guaranteed under the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. OBRA-89 amendments to EPSDT guarantee access to all federally reimbursed Medicaid coverable services, even if the service is not included in the state's Medicaid plan. Current systemic barriers however, have impeded the actual receipt of these comprehensive services by children who are eligible.

What are some of the current barriers to meeting foster children's health care needs?

Delays in establishing Medicaid eligibility. Long delays of several weeks or more can occur between the time that a child is removed from a parent's home and a petition is filed to make the child a dependent of the state. During this time the child may be ineligible for Medicaid, creating severe financial burdens for foster parents or depriving the children of access to health care entirely.

Low reimbursement rates in Medicaid. Many health care providers are discouraged by low Medicaid reimbursement rates from caring for children in foster care. This has created a crisis in availability and quality of services to this population.

A fragmented health and human service system. Even though children in out-of-home care need a comprehensive continuum of services to meet the wide range of their needs, the current service delivery system is fragmented with inadequate service capacity for many kinds of health services, particularly for mental health and developmental services. Basic organizational problems that result in fragmented delivery systems make it difficult for social workers, foster parents, and other caregivers to find providers, coordinate services, and make sure that children get the services and treatment they need.

What approaches have improved the delivery of health care to foster children?

Innovative models exist for providing appropriate health care to children in foster care. Several innovative health service delivery models have been developed in Connecticut, Oakland and Los Angeles, in California, and Syracuse and Rochester, in New York, to customize and more efficiently provide health services to foster children consistent with recommended standards of care. Los Angeles, for example, is planning and beginning to implement an integrated health and mental health system for the 50,000 children in protective custody in that county. The Los Angeles model uses regionalized multidisciplinary assessment and treatment centers specifically for children in foster care. These regionalized centers serve as hubs to provider networks of physicians, psychologists, and other therapeutic programs that surround each center and provide ongoing primary and specialty care to the children in the system. Public health nurses are stationed in the Department of Children's Services to serve as health care case managers and to provide a human link between the child welfare system and the health service delivery system. Once in place, this system should provide a comprehensive continuum of services and reduce child welfare costs caused by multiple placements due to deterioration of mental health and untreated behavioral problems.

Efforts to build effective systems for providing health care for children in foster care rely heavily on Medicaid reimbursement. California, Connecticut, New York, and other states have used Medicaid to help finance innovative programs to meet the needs of children in foster care and other vulnerable populations of children. These innovations have been possible through the state's use of Medicaid waivers, the expanded the use of standard Medicaid financing, particularly through the use of the rehabilitative services options under Medicaid, and the use of Medicaid to cover case management and additional administrative costs. Unlike demonstration programs and block grants, Medicaid has provided sources of funds that are ensured and continuous.

Health Care Access for Children in Foster Care Under the President's Plan

Positive Aspects of the President's Plan for Foster Children

All children in foster care would be entitled to the "comprehensive benefit package." All children (with the exception of undocumented immigrant children), including all children in foster care, would be entitled to the services in the comprehensive benefit package in the President's plan. Coverage for all foster children addresses some major gaps in the current system -- gaps which occur because of delays in establishing Medicaid eligibility, gaps which occur because certain children in state-subsidized foster care programs do not meet the income eligibility guidelines for Medicaid, and gaps in access to basic health and mental health services which occur because of low Medicaid reimbursement rates. Other groups of children for whom access to even basic health care has been a problem would also be eligible for the basic

comprehensive benefit package—some of these children are in and out of foster care. These include children with special needs who are receiving federal or state adoption assistance payments, as well as children in the care of juvenile justice agencies. For some of these children, and others in foster care, the services in the comprehensive benefit package alone would be adequate to meet their needs for preventive and treatment services; for others the comprehensive benefit package would be insufficient.

Some children in foster care also would be entitled to supplemental benefits to address their special needs. In addition to the comprehensive benefit package, the President's plan would establish a totally federally financed program to provide a range of supplemental services that are currently available to children under Medicaid. These include services provided under the expanded Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program. Currently, services available under Medicaid and EPSDT address a broad array of physical, mental, and developmental disabilities that frequently occur among many children in foster care. Children in the federal foster care program authorized under Title IV-E of the Social Security Act would continue to be eligible for these new supplemental services, as well as the proposed comprehensive benefit package, because they are defined for purposes of the plan as "AFDC recipients." Other children in state supported foster care who are not eligible for IV-E, many of whom are now eligible for Medicaid, would qualify for the supplemental services only if they meet certain family income eligibility standards.

Children in foster care could benefit from implementation of some of the activities supported by the Public Health Services Initiatives Fund. The President's plan establishes a Public Health Services Initiatives Fund that will support a range of activities to benefit underserved and hard-to-reach populations and special initiatives to promote the delivery of preventive services, mental health and substance abuse services, school-related health services, and health research. Children in foster care could benefit from these initiatives, although they are not specifically designated as a target population, nor are specialized delivery centers specifically designed for children in foster care targeted as essential providers. Moreover, it is not clear how funds for coordination activities, such as case management, and systems building and integration activities, could be supported through this funding mechanism. It is also important to understand that this is a discretionary fund, and does not ensure the security of an entitlement.

Limitations for Children in Foster Care in the President's Plan

1. Limits on Eligibility

The patchwork of eligibility for different services packages in the Health Security Act would limit access to expanded services for some children in foster care. The President's plan would provide all children, including those in foster care, with eligibility for the benefits included in the comprehensive benefit package. However, eligibility for expanded benefits through Medicaid or a new federal program for children with special needs would depend on the child's financial status or receipt of AFDC or SSI cash assistance. While children receiving foster care or

adoption assistance benefits under Title IV-E of the Social Security Act are included within the definition of "AFDC recipient," and would therefore be eligible for expanded benefits, some of the following groups may be ineligible:

- **Children in state-supervised foster care who are not IV-E eligible.** There are many children in state-supervised foster care who do not meet the eligibility requirements for the programs funded under Title IV-E of the Social Security Act, but may have the same needs for specialized services. These children generally receive state-funded foster care benefits and are included as Medicaid-eligible children in the state's Medicaid plan. Under the provisions of the President's plan, however, many of these children would not fit the definition of "AFDC recipient" or "SSI recipient" and might not qualify for supplemental benefits depending upon how their family income is determined.
- **Children receiving state adoption assistance payments.** Many children with special needs, who have been in foster care and are adopted, qualify for either federal or state adoption assistance payments. Eligibility for federal adoption assistance payments under Title IV-E of the Social Security Act currently allows a child to retain Medicaid eligibility after adoption. Under the President's plan, a child receiving IV-E adoption assistance would be considered an "AFDC recipient" for eligibility purposes and thus could receive expanded benefits either under Medicaid or under the new federal program. Children receiving-state funded adoption subsidies without IV-E assistance, although indistinguishable from the federally-eligible children in terms of needs, will not be eligible. The absence of access to supplemental benefits would likely serve as a deterrent to finding permanent adoptive homes for children with special needs.
- **Children in the juvenile justice system.** Under the President's plan, children in the juvenile justice system would be eligible for the comprehensive benefit package. However, these children, like children in foster care, often have a high incidence of serious physical and mental health problems, and may need specialized services as well. However, some of these children experience multiple placements in both the child welfare and juvenile justice systems, moving among detention facilities, correctional institutions, group homes, and foster homes. While in group homes or foster homes some might be eligible for IV-E benefits and thereby qualify for supplemental benefits as "AFDC recipients," some also may be financially eligible for the supplemental benefits. If they qualify for the supplemental benefits only while in foster homes and group homes, but not other placements, serious discontinuity in their health care could occur, potentially compromising their health status.

2. Limits on Benefits

Benefit levels would depend on financial criteria and health status. The specific scope of benefits to which children in foster care would have access under the President's plan would depend on both their financial circumstances and their health status. All children in foster

care, juvenile justice facilities, or state supported adoptive placements would be eligible for the comprehensive benefit package. Those children who meet financial eligibility criteria or are AFDC or SSI recipients would be eligible for supplemental benefits under Medicaid or the new federal program. Children with severe physical or mental disabilities would be eligible for community-based long term care services under a new long term care benefit program.

Foster children who do not qualify for either supplemental benefits or long term care, however, would be able to receive only the services covered in the comprehensive benefit package. This package contains some limitations on services that could adversely affect children in foster care who currently are eligible for Medicaid. These limitations include:

- **Limits on the frequency of preventive visits.** The frequency of clinical preventive visits covered under the President's plan does not equal the frequency recommended by the American Academy of Pediatrics, nor ensure the content recommended by the federally sponsored Bright Futures Project. Children in foster care require comprehensive health assessments, including mental health and developmental assessments, at least as often, if not more often than other children. The greater risks faced by children in out-of-home care, many of whom move frequently and cannot rely on their own parents or other permanent families to address their health and mental health needs, demand frequent monitoring of their health status.
- **Limits on mental health services.** Children in foster care, as a group, have more extensive needs for mental health services than many other groups of children. For example, a study in California in 1988 showed that although children in foster care represented approximately 4% of Medicaid enrollees, they consumed over 40% of the expenditures for mental health services for all enrollees less than 18 years of age. While some children in foster care with mental health needs will be eligible to receive a broad range of services under the supplemental benefit provisions for children with special needs, other who must rely on the mental health services in the "comprehensive benefit package" in the President's plan are less likely to have their needs met. Limits on the scope and duration of these mental health services, and trade-offs between inpatient and less restrictive benefits, that are imposed until 2001, will seriously restrict their usefulness in addressing the comprehensive needs of children with serious emotional disturbances. The cost sharing requirements are likely to further curtail access to these services. Without appropriate services, the needs of these children are likely to intensify and require more restrictive and costly services, thus resulting in increased costs for the child welfare, mental health, and health systems in the future.
- **Limits on home health care.** Some children need health services, in addition to mental health services, delivered in the home setting. Under the President's plan these services would be available to them only as an alternative to institutionalization after an illness or injury. Thus, children in foster care would only be eligible for such services once their condition had deteriorated to a point requiring institutionalization rather than as a means of preventing such

deterioration. For children with congenital or developmental problems, such services would not be covered at all. Moreover, private duty nursing is excluded from coverage entirely even though is a critical component of home care for children with severe health problems.

- **Limits on outpatient rehabilitative services.** The President's plan would cover outpatient rehabilitative services such as occupational, physical, and speech pathology services only in cases of illness or injury. Such services are not covered to address problems that are congenital or developmental in origin, and this restriction would adversely affect many children in foster care with chronic physical, mental, or developmental conditions. In addition, these rehabilitative services are limited to 60 days unless functioning continues to improve. For some children in foster care, however, these services are needed to enable them to maintain rather than improve their level of functioning. In addition to rehabilitative services, regular habilitative services are essential for this group of children who are especially vulnerable to predictable disruptions due to planned or unplanned moves, or other stressful events in their lives.
- **Limits on hearing services.** The President's plan would cover some hearing services for children. However, hearing aids would not be covered. Most foster parents would be unable to pay for hearing aids for their foster children and are not legally obligated to do so. A child in foster care would therefore be dependent on the willingness of the state to provide separate coverage for hearing aids. The lack of a hearing aid for a child in foster care who needed one could have severe adverse developmental, social, and education consequences.

3. Absence of Procedures and Safeguards

Disputes may take place regarding the financial responsibility for the cost of health care for children in foster care. Although all children in foster care would be eligible for coverage under the President's plan, it is not clear *who would be responsible for enrolling a foster child* in a health plan or for paying the premium—the child's biological parents, the foster parents, or the state or local child welfare agency. It is also unclear *whether children in foster care would be eligible for subsidies* for their premium costs and, if so, the extent of the subsidy. Also, when children are placed in foster care in locations other than where their parents live, it is not clear *which regional alliance will receive the premium and pay for the care*. As children move from foster home to foster home, back to the biological family or to an adoptive home, it is unclear *how immediate and continued coverage will be ensured*. Because children in foster care have, on the average, more extensive health care needs than other children, plans may be reluctant to serve this population unless the risk adjustment system takes these needs into account. It is also unclear *who would bear the burden of cost-sharing and copayments* for foster children.

Portability of coverage would not be assured. Under the President's plan, children in foster care who were moved to a placement outside of the jurisdiction of the health plan in which they were enrolled would be eligible only for urgent care. Registration with a new alliance or enrollment in a new plan is contemplated only for individuals who establish residence for a

minimum of three months. For children in foster care who move frequently this would lead to disruption of coverage for non-urgent but nevertheless essential services.

Children in foster care often need service from multiple providers, many of which will presumably be out-of-plan. Many children in out-of-home care, especially those in group homes or other residential facilities, receive health and mental health services from multiple providers, including providers employed by the group home, such as nurses and psychologists. Placement, in fact, may be determined by the availability of such providers on site. It is not clear whether, and how, continued access to these and other specialty care service providers will be available. While the President's plan requires health plans to offer the option of obtaining services from out-of-plan providers, in most instances a much higher co-insurance rate would apply for these services.

4. Limits on Innovative Service Delivery Approaches

Funding would not be available to support case management services essential for delivering appropriate health care to children in foster care. Because children in foster care have complex health care and other service needs, case management and other coordination services are essential for providing them with effective and efficient health care. Although case management is currently an optional Medicaid service, many states are using the targeted case management option to provide more appropriate care and to achieve cost savings through regionalization, coordination, and integration of services for children in foster care. Only children eligible for the expanded benefit package, long-term care, or specific mental health services would be eligible for case management services, and even then the scope of these services may be less extensive than what is currently available in some locales.

Model programs providing innovative and effective services to children in foster care would be threatened. Many of the innovative programs that have successfully customized health care services to more efficiently meet the special needs of children in foster care have done so by making creative use of funding under the Medicaid program. To the extent that children in foster care would no longer be eligible for Medicaid supplemental services, and the national guaranteed benefit package would not cover the full range of services that are currently covered under Medicaid (case management options, rehabilitative services, and clinic options, and administrative costs), these innovative programs would be undermined. Even if all children in foster care were eligible for expanded service benefits, it is not clear if sufficient funds will be available to support alterations to the service delivery system, such as regionalizing and integrating services within comprehensive centers.

5. Threats to Other Public Child-Serving Systems

The integrity of state and local child welfare programs could be threatened. State and local child welfare programs are mandated by federal law (Adoption Assistance and Child Welfare Act) as well as by state law to provide appropriate health care services for children in

foster care. A state's legal obligation to provide this care exists regardless of the coverage in a national benefit package, and the state is not relieved of this obligation simply because the guaranteed benefits are not sufficient. To the extent that the child welfare system has successfully met this obligation it has often done so by relying heavily on the Medicaid program to finance the cost of these services. Although the federalizing the supplemental benefit program for eligible children will help, there will be considerable numbers of children in foster care who do not qualify, and the cap on federal spending is likely to limit the scope of service available. If the current financing mechanisms for Medicaid services, are no longer as broadly available, the child welfare agencies may have to struggle to meet their legal obligations to children in out-of-home care and may suffer from severe increases in the costs of meeting those obligations. To the extent that costs currently shared between the state and federal government under Medicaid are shifted to the state and local governments, unacceptable burdens will be placed on a system that is already severely over stressed.

The ability of states and local school districts to comply with special education requirements would be threatened. States and school districts are currently obligated by state and federal law, specifically the federal Individuals with Disabilities in Education Act (IDEA) and its part H, Early Intervention Program (P.L.99-457), to provide children with disabilities a broad range of special educational and related health services. To the extent that these related services are covered by Medicaid, that is the source of funds that pays for them. To the extent that children in foster care requiring special education and related health services would no longer be eligible for Medicaid, a major financial burden would be transferred to the states and local school districts to pay for the required services. School districts can ill afford the increased burden.

Proposed Solutions

1. Eligibility

Ensure that all children in foster care are eligible for the same basic and supplemental benefits. Extensive documentation exists that children placed out-of-their homes are at increased risk for serious health problems. Their need for comprehensive health services does not depend on whether they are placed in foster care, juvenile justice facilities, or adoptive homes. It also does not depend on whether their placements are supported by federal or state funds. *Therefore, all children in out-of-home care should be eligible not only for the comprehensive benefit package, but also for expanded benefits available under Medicaid or a new supplemental federal program.* This could be achieved by ensuring eligibility for both the comprehensive and expanded benefits for at least three groups of children:

- all children in state-supervised foster care regardless of whether their placements are funded by federal (IV-E) funds or state funds;

- all special needs children placed for adoption regardless of whether their adoption subsidies are paid for by federal (IV-E) or state funds; and
- all children placed in the juvenile justice system, whether in detention or correctional facilities. (Although current law excludes these children from eligibility for Medicaid, under any health care reform plan they should be treated comparably to other children in out-home-placement.)

Ensure that children in foster care are eligible for premium subsidies and exempt from copayments. Under the President's plan, premium subsidies would be available to certain low-income children and reduced copayments would be available to AFDC and SSI recipients. While many children in foster care placements would qualify for this financial assistance, determinations of their eligibility would be made far more complex by virtue of their separation from their birth families and lack of clarity concerning whose income should serve as the basis of eligibility determination. The logistics about who would make copayments and how payment would be made, potentially creates other burdens and unnecessary barriers. This could involve significant delays and substantial administrative costs. *Therefore, any health care reform plan should specify that children in out-of-home care would be eligible for premium subsidies and exempt from copayments.*

2. Benefits

Ensure that children in foster care have access to a comprehensive set of services that is sufficient to meet their needs. Children in out-of-home placement must have access to a comprehensive set of benefits that is sufficient to meet their complex health and mental health care needs. Any health care reform plan should ensure that a broad range of benefits are available to these children. This could be achieved by doing the following:

- **Extend current EPSDT protections.** Any plan should specify that all children in out-of-home care would be eligible, at a minimum, for the services currently guaranteed to Medicaid eligible children under the EPSDT program. To the extent that these services are not covered under a national comprehensive benefit package they should be available to children in out-of-home placement either through an extension of Medicaid coverage or through a new expanded benefit program.
- **Clarify the definition of mental health services.** Any health care reform plan should make clear that the outpatient mental health services that are covered, include the home-based, foster home-based, and family-based therapies needed by children in foster care.

- **Eliminate the limits on mental health services, home health care, rehabilitative and habilitative services, institutional care, medical equipment and devices, and hearing aids.** Because of the special needs of children in foster care, certain services should be available to them without any limitation other than medical necessity as defined from a pediatric perspective (see Section 3, below). Any health care reform plan should provide access to any services not included in the comprehensive benefit package but currently available under Section 1905 of the Social Security Act, that are identified as medically or psychologically necessary by a health care professional, or identified as necessary in a child's individual service plan under the IDEA, or in a child's case plan under the Adoption Assistance and Child Welfare Act.

3. Procedures and Safeguards

Ensure that the needs of children in foster care are addressed and protected at each level of government and administration. Any health care reform plan should ensure that the needs of these children are specifically addressed by each governmental and administrative entity with responsibility for implementation of health care reform. Specifically, under the President's plan, the needs of children in foster care must be addressed and protections adopted by:

- the responsible federal agencies;
- the National Health Board;
- states;
- health alliances; and
- health plans.

Ensure that standards and procedures are adopted which would address the special needs of children in foster care. At minimum, any health care reform plan should ensure that standards are in place that would address special issues of eligibility, scope of benefits, portability of coverage, procedural safeguards, and quality assessment procedures that are appropriate for children in foster care.

Ensure a child specific standard of medical necessity. Because "medical necessity" is a standard that is used to determine whether or not a benefit is provided, it plays a pivotal role in modifying those benefits which are actually provided, versus those that are potentially available. Over the past ten years the notion of medical necessity has been transformed in both practical application and legal enforcement from a physician determined criteria for inclusion of a particular service, to a health plan determined criteria for exclusion of services. If services are to be excluded at the discretion of a health plan, this exclusion must account for the special developmental vulnerability of children and their unique dependency status. For children in foster care who are even more vulnerable, the standard of medical necessity must account for their unique health, mental health, and developmental needs, and be determined by the primary physician responsible for their care.

- *Ensure that health plans have proper incentives to care for children in foster care.* A designated risk adjustment in their payments may be necessary.
- *Ensure that quality is guaranteed.* Require that a quality assessment system tracks key structure, process, and outcome measures specific to this population of children.

Continue to support innovative models of delivery that provide comprehensive and integrated services for children in foster care. Since a large proportion of children in foster care may have needs that are not effectively or efficiently encompassed by health plans, support of new service delivery models must continue. The development of models should become a priority of the Public Health Service. To support this, the national plan for health care reform should guarantee a source of funding that can be used to build the coordination and case management systems, extended service benefits, and alternative delivery mechanisms that are essential to comprehensive and integrated services. The plan could specify that children in foster care are one of the vulnerable populations intended to benefit from the Public Health Service Initiative Fund, or require that a portion of the Public Health Service Initiative funds are to benefit children in out-of-home care. The plan could also specify that special programs developed to provide health care services for children in foster care be designated as "essential community providers." A high priority should be placed on conceptual, financial, and physical integration of services.

Conclusion

Children in foster care have long been limited in their access to essential health care. Combined with their vulnerability in numerous other respects, this deprivation significantly increases their risk of growing up without the necessary health and functional capacity to participate normally as adults in society. Health care reform presents an excellent opportunity to increase the level of protection in the health care system for the special needs of this population and to increase the likelihood that they will receive the health care and related services they need. The President's plan, as introduced to Congress in November 1993, has made a strong beginning toward improving the health services available for children in foster care. Unless additional steps are taken to address the gaps in the plan, some children in foster care will continue to receive less than they need. The solutions proposed could address many of these potential shortcomings.

Mr. WAXMAN. Dr. Redlener.

STATEMENT OF IRWIN REDLENER

Mr. REDLENER. Thank you, Mr. Chairman and members of the committee. I am Irwin Redlener. I am president of The Children's Health Fund and Director of the Division of Community Pediatrics, Albert Einstein College of Medicine, at the Montefiore Medical Center in New York.

Our division actually is the institutional headquarters for something called the New York Children's Health Project, which is currently the Nation's largest health care program for homeless children. It has been operating since 1987, utilizing fully equipped mobile pediatric units to serve these children, and also utilizing computer-based medical records to assist in organizing and tracking medical data, immunizations and other essential information.

We also provide health services to runaway youth and children in foster care, et cetera. But our foundation at the children's health fund has actually replicated this program we have in New York in diverse communities around the United States. I am saying this to give context to my remarks.

The populations that we are currently serving other than New York include homeless children in Dallas, Tex.; inner city underserved children in Newark, N.J.; South Central Los Angeles; and the Anacostia district here in D.C., highly isolated poor children in the Mississippi Delta, and in the South Florida communities that were recently struck by Hurricane Andrew.

The point is that all of our patients live in poverty and many have some degree of housing instability and most of them frank homelessness. Virtually all of these children share one common bond, however, which is that they are clearly and explicitly medically unserved or underserved. Because of homelessness around a host of other factors, they experience profoundly difficult and sometimes insurmountable barriers to acquiring the appropriate health care they need through the traditional routes, including access to community clinics and public hospitals. All of this is a problem for these populations.

These children I am referring to are what we have currently been calling medically homeless, that is to say, these are children who lack a place where their primary care is delivered in a coordinated, organized fashion where medical records are kept, where the families are known, et cetera. It is in that context of medical homes that children get the best care and most appropriate care, and end up getting their immunizations delivered. And it is children who are medically homeless that we are deeply concerned about.

I want to say a word because people are not probably aware of how many medically homeless children there are in the United States. Our estimates are that if you count the children living with families who are medically underinsured as far as pediatric care is concerned, and including children who live in the federally designated health shortage areas in the United States, and those who are officially homeless, runaways, children in underserved migrant communities, we are estimating some 12 to 15 million children in the United States are what I consider to be medically homeless;

that is, without a constant appropriate place for getting their health care.

These children represent an unbelievably difficult challenge to anybody's notion of delivering on the problem of universal access to health care. I think that when the final analysis comes, our ability to provide universal access will be much more difficult than our ability to control costs. And I think to approve the appropriateness of the final health plan, we will have to look at how well we have done and how well we have served these children who represent a true national tragedy in terms of their scope and ubiquitousness in the United States in terms of not getting the health care that they need.

I really just wanted to make six specific recommendations with regard to health reform as it affects the children that myself and my colleagues are so deeply concerned about. The first thing is, before doing that, I would just want to echo Dr. Halfon's suggestions about the national standards which I think should really be a core piece of what is done for health reform for kids.

The six points I wanted to mention specifically with reference to the populations I have been referring to are as followings. One is that I don't think we can tolerate a health reform bill that is not exceedingly explicit about a time certain schedule by which everyone in the country will be included in the plan.

I would very much object to, on a number of grounds, any plans that suggested when we would figure out universal access would come. I think we and our children deserve that to be as quickly as possible, certainly no longer than 3 years from the time of passage of health reform.

Second, there are concerns about flexibility that States might have about assuring and safeguarding the needs, the medical needs of children and access to care for these children. I think that Congress ought to look very carefully at the assurances and safeguards in the bill as it comes through the process.

Third, I don't think we should tolerate discussions about health reform plans that are not explicit about the health benefits package. I would reject out of hand any plan that does not get explicit about exactly what benefits are provided.

Fourth, we have to make sure that the health reform proposal which is clear enough to me, and the President's bill creates ways of bringing comprehensive health services to underserved and special needs populations, including the enabling services that these people need to make sure their health care is truly there for them.

Fifth, we are very concerned about the prospects of uncontrolled enrollment of medically underserved and homeless children in managed care plans. There are a number of issues I think need to be attended to with regards to making sure that if this is the case, that is that children who are homeless will be put into managed care plans, there are a number of safeguards, which are delineated in my written testimony that I won't go into now, but they must be attended to.

The sixth and final thing I am deeply concerned about is the question of: Will homeless children and other medically underserved children in underserved populations in general be subject to the annual appropriations process to determine whether or not

they will get what they need to get in their health care. What are we going to do to safeguard these children in these populations from that annual process which every single year risks what is available to them in terms of what their clear needs are?

In conclusion, finally, I would say that I don't know how to express this strongly enough, but on behalf of myself and the children that we take care of and many of my colleagues around the country, we were offended and terribly dismayed at recent statements to the effect that our health care situation in this country is not a crisis.

For the probably 400,000 children in New York City and their families I know personally do not have regular access to appropriate care. That kind of really uncalled for elimination of the notion that we are dealing with a crisis here is really of deep concern to me. I hope that the political needs and the political agendas of people won't keep us from focusing very vigilantly and very aggressively on solving the health care access needs for America's children.

Thank you.

Mr. WAXMAN. Thank you very much.

[The prepared statement of Mr. Redlener follows:]

STATEMENT OF IRWIN REDLENER, PRESIDENT,
THE CHILDREN'S HEALTH FUND

Medically Homeless Children

The Division of Community Pediatrics at Montefiore Medical Center is the institutional headquarters for the New York Children's Health Project, the nation's largest health care program for homeless children. Since 1987, this initiative has been providing health care via fully-equipped mobile medical units run by pediatrician-led full-time teams using computer-based medical records to organize and track medical data. We also provide comprehensive health services to runaway youths and adolescents in foster care.

In addition to these services, we have recently opened a fixed-site, multidisciplinary, "one stop shopping" children's health facility in the South Bronx. This new center serves primarily, but not exclusively, recently housed, formerly homeless families.

Our foundation, The Children's Health Fund, has replicated the mobile-based health services model in diverse communities throughout the United States. Target populations in these other sites include homeless children in Dallas, Texas; inner-city urban children in Newark, New Jersey, south central Los Angeles and the Anacostia district of Washington, D.C.; rural and semi-rural highly isolated poor children in the Mississippi delta, western West

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Virginia and in the south Florida communities struck by Hurricane Andrew.

All of our patients live in poverty and many have some degree of housing instability (if not frank homelessness). Virtually all do share one common bond, however: they are medically underserved or unserved. They experience profoundly difficult, sometimes insurmountable barriers in acquiring appropriate health care through traditional routes, including neighborhood or community clinics and public hospitals.

What these children lack is what pediatricians refer to as a **medical home**, that is a place where children get comprehensive acute and preventive health care by user-friendly providers who know them, and their medical histories. A medical home is where immunizations are given and tracked. It is a place where special services are organized and where extended services are offered.

I emphasize this concept of the medical home because that is the notion that should drive the design of health services for children at risk, really all children, if we expect to have at the end of the day a health care system that can truly accomplish universal access. Its not that my patients can't get some kind of health care when they are dying. Its just that they get the wrong kind of care at the wrong time and in the wrong place. They may be served by short-lived categorical programs; they often get episodic and sporadic care.

As a result of all this, patients who are poor and without medical homes are chronically medically underserved. And whether they live in the Mississippi delta or a New York City welfare hotel for homeless families, they are not immunized, their chronic conditions are not identified or cared for and, in incredible numbers, their learning and school performance are hampered by medical problems which have not been appropriately attended to.

I refer to these primary care deficient children as **medically homeless**. By this I am referring to any child who is not receiving basic, preventive focused, continuity focused health care.

How many such children are there in the United States? If we count the children who experience financial barriers to health care because the family's coverage does not include them; if we include the children living in the 2,000 plus federally-designated Health Personnel Shortage Areas; if we include the homeless, the runaways, the children of underserved migrant communities and the children in grossly underserved inner cities, I estimate that some 12-25 million American children - at a minimum - are medically homeless.

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Barriers to Achieving Universal Access

And, members of the Committee, we will never achieve true universal access to appropriate health care in this country until we understand and meet the challenges represented by our medically homeless child population. That is why it is so essential that the legislative process remains vigilant to the task of safeguarding the principles, programs and resources necessary to ensure access for these special populations.

The fact is that delivering on the promise of universal access is no small feat. In many ways it is more difficult than controlling health care costs. That is why single-payer, fee for service, Canadian style reform has been so appealing for many of us who have worked with the most challenging populations.

But, a single-payer system, at least for the United States, simply does not sufficiently address the needs of the most difficult to reach populations. I will detail why I feel this is so later.

On the other hand, I do believe that the Health Security Act comes much closer to providing what is needed and can provide the access we'd like to achieve.

Universal access, on the simplest level starts with eliminating fiscal barriers, but ends with facing challenges of extraordinary complexity where we must commit to solving access problems like:

- severe health personnel shortage areas
- language and cultural barriers
- endemic poverty
- homelessness and workforce migration
- family dysfunction and community violence
- HIV and a host of environmental health hazards which affect large population sub-groups

Why have we had such problems meeting these challenges?

It is not that we haven't tried to cover such needs and such populations, nor is it that we lack committed public health specialists -in and out of government - who are concerned about these types of health care delivery challenges.

The problem is that we have become a nation of tinkers. We

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have built model programs, created demonstration projects and special initiatives by the hundreds. They are funded by foundations, private fund-raising efforts and government grant programs that come and go endlessly.

We can't seem to kick the habit of isolated, quick-fix categorical programs and episodic, disorganized health services for the very people, like children, who most need to have organized, comprehensive, coordinated services. We have a penchant for quick, short, underfunded responses to health problems that cry out for sustained, institutionalized changes in the way we conduct our health care system from financing to health professional training to the development of appropriate resources.

I'm a pediatrician, not an economist, so while I do appreciate the need to control the cost of health care, we urgently need reform to make sure that our country is able to ensure that all people have a fair and equitable access to comprehensive health services. I believe that the Health Security Act can make this happen as long as the elements which ensure true universal access are recognized and adequately preserved during the legislative process.

What must be done

Let me be very specific: here is what we must do in order to make sure that every person, every child in the United States benefits from the promise of universal access:

1. Health reform must include a real and measurable commitment to universal access in accordance with a "time certain" schedule to be completed within three years of passage of health reform legislation.
2. State flexibility must be allowed to proceed only with sufficient assurances and safeguards to make certain that all individuals from all racial, economic and special population groups are appropriately included in the health care system.
3. No bill should be considered that does not include a detailed description of the benefits to which all people are entitled and those benefits must be sufficiently comprehensive, preventive, supportive and interventive.
4. The reform proposal must include, as does the Health Security Act, appropriate enhancements of the public health infrastructure to improve our ability to do disease surveillance, screening and

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other classic core public health functions.

5. The proposal must explicitly describe the methods for ensuring access to underserved areas or special needs populations. The Health Security Act does this.

6. A reformed health care system should permit and enable health providers, and their organizations, to create ways of bringing comprehensive health care to underserved populations. Such measures would include development grants for health plans, recognition of and support for essential community providers, increasing resources for community health centers, National Health Service Corps, regional academic health centers, etc.

7. For homeless, housing unstable or transient families in particular, there are great dangers in the prospect of uncontrolled "enrollment" in managed care plans. For such groups, there must be:

- * specific measures to protect these families from being bound to provider systems which lock them into a single point of service;

- * safeguards to ensure that care is being provided by providers experienced with and committed to the special needs of these populations;

- * mechanisms to monitor the quantity, appropriateness and quality of services provided to people who do live in fixed neighborhoods with stable housing;

- * availability of resources to support innovative and special initiatives, like mobile-based medical services or computer-based health records and tracking systems.

7. The Congress must understand the health care needs of the poor, the homeless, migrant populations, isolated rural families and inner city families in order to protect the services designed to meet special population needs. Specifically, such services must be protected from the annual appropriations process, itself subject to unrelenting political and economic pressures.

Problems with Single-Payer, Fee-for-Service Approach

Finally, if we can do this right, I am convinced that the Health Security Act has the best chance of getting to the promise of universal access for the underserved and special needs populations in the United States. The single-payer, fee-for-service

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approach is potentially a viable alternative, but it has serious problems:

* Fee for service, single payer systems (FFS) have no special ability to cope with underserved areas as compared, for instance, to the President's proposed initiatives to identify and support Essential Community Providers or provide resources for Accountable Health Plans to develop services in areas of need.

* FFS does not encourage much needed interdisciplinary health and health related teamwork to the extent that this would be enabled under high quality capitated systems. Such coordinated services are precisely what is needed by the special populations I have been discussing.

* FFS in the U.S. would be driven by a wildly imbalanced generalist/ specialist ratio. We have nearly the opposite distribution to that seen in most of our industrialized nation counterparts where 2/3 to 3/4 of practicing physicians are generalists.

* As opposed to peer reviewed, quality oriented health plans, it is exceedingly difficult to monitor and address quality issues among isolated, FFS type health care practices.

* FFS, single-payer systems are tax financed. They are, therefore, perpetually vulnerable to political decisions and economic pressures which would, first and foremost, endanger services to the underserved and most vulnerable populations.

Conclusion

In conclusion, it is clear that our country is badly overdue for major reform of its health care system. For many of us who have spent our careers trying to understand and meet the needs of the millions of medically underserved men, women and children, the President's proposal offers the most hope, the most promise for getting equitable, comprehensive health care to all of our citizens. We ask the Congress to be vigilant on behalf of the issues which most affect the people least able to work this complex legislative process, least able to make their own voices heard.

Thank you.

Mr. WAXMAN. Dr. Nickey?

STATEMENT OF LAURENCE N. NICKEY

Mr. NICKEY. Good morning. Thank you, Mr. Chairman, and members of the committee for the opportunity to speak with you today about border health problems. I am Laurence Nickey, Director of the El Paso City Health and Environmental District, and a retired pediatrician. But I am here today on behalf of the four border States medical association as well as their medical societies to speak in support of H.R. 2305, Congressman Coleman's bill which calls for the establishment of a U.S.-Mexico Health Commission.

My remarks are brief and I want to emphasize three points.

The border, Mr. Chairman, is in crisis. Somebody has said that the border is burning and we need to extinguish it. The health problems that originate in the border region impact the rest of our country very seriously. And third, the consensus of all the experts on border issues is that we must establish this U.S.-Mexico Border Health Commission to address these problems.

The United States shares a 2,000-mile border with Mexico—geographical borders are just lines on a map which do not protect us from the diseases that are originating there. Even though there are two sovereign nations, for purposes of public health, this is a single, large population sharing the same air, the same water, the same pollution, and the same diseases on an immediate basis. What affects the public's health on one side certainly affects it on the other side.

In the year 1900, Mr. Chairman—we won't include San Diego—there were 36,000 people living along the entire 2,000-mile border. Today there is well in excess of 7 million people, a large share of whom are desperately trying to better their way of life and that of their families.

A once rural and very sparsely populated area has quickly been transformed into an urban setting containing very carelessly and often illegally subdivided land with uncontrolled sewage disposal and the contamination of drinking water from subsurface shallow wells spawning high rates of hepatitis and gastrointestinal diseases.

This incredible increase in population has put an enormous strain on local communities. The residents of Juarez, Nuevo Laredo, and Tijuana, just to name a few, have literally outstripped their infrastructure. Local governments on both sides are under serious strain to provide potable water, sewage disposal, electricity and health facilities.

From Brownsville, Tex. to San Ysidro, Calif., hundreds of colonias sit north of the border. Close to 200,000 live in these largely unincorporated settlements. San Diego County has an estimated 55,000 Mexican immigrants, many of whom live in colonias. El Paso is surrounded by over 300 colonias.

The result of this infrastructure is a higher incidence of many infectious and communicable diseases, including tuberculosis, hepatitis, and even malaria may abound. With the passage of NAFTA, this population concentration will only intensify and this burden on infrastructure will only increase.

The problems of increased infectious disease are not limited to Texas, California, New Mexico, or Arizona. Please note that there are in excess of 400 million legal northbound only border crossings each year as people visit family, do business, shop, and seek jobs. In El Paso alone, this past year there were almost 61 million border crossings between Juarez and El Paso, again, northbound and legal. You don't keep chicken pox on the north side of the river and measles on the south side of the river. It just doesn't work that way.

The migration of border residents throughout the country make border health problems a national concern. Demographic patterns can take health problems to Dallas. For example, the measles epidemic witnessed not too long ago originated in Monterrey, Los Angeles, and Chicago also, just to name a few cities. In fact, the measles in Washington State was traced to our southern neighbor. And the increases in tuberculosis cases in the border States, many of which have their origin in Mexico, are indeed a ticking time bomb for the rest of the country.

Unfortunately, the current health care reform proposals do not address these very unique and serious border health problems. How will individuals crossing the border in search of medical care at hospitals or public clinics be treated, especially if direct services are eliminated from the public health system as is proposed in the current plan? How will an employer-based health system meet the needs of unemployed resident aliens? Medicaid and local funds are already stretched to the limit.

The commission proposed in H.R. 2305 has the capability to address these issues by giving us access to new funding mechanisms, including those international in origin. Just as the causes of these problems are international in origin and scope, so too are the solutions beyond the community level.

They have even surpassed the capability of the States. State and local communities are trying to address these issues as best they can—from local agreements with Mexico's counterparts to deal with pollution and vector control issues to water bonds for the colonias among many others.

However, H.R. 2305 addresses Washington's role. It recognizes that the staggering health problems which cross all political boundaries can only be addressed by an international authority.

NAFTA does not address these issues either. While it does contain a side agreement on the environment, the focus is narrowly drawn and does not include the health problems I have alluded to.

The American Medical Association, the medical societies and associations in the four border States and the public in general and the public agencies assuredly of all these States all support the establishment of a permanent United States-Mexico Health Commission. I have brought written testimony from several organizations to enter into the record, Mr. Chairman.

It is clear that if we do not address these issues soon, they may escalate to a point such that we cannot capture them. As a representative of physicians who must deal with many of these public health problems on a daily basis, I respectfully urge your support of this much-needed legislation. I would be happy to answer any questions.

With that, Mr. Chairman, I welcome you to the other America and the forgotten border. Thank you.

Mr. WAXMAN. Thank you very much.

Gentlemen, you have given us excellent testimony. It is going to be very useful as we consider the President's plan. But the President's plan envisions covering the migrant workers, foster children, and the homeless by giving them a card, and that card is supposed to make every person who has it, every American who has it eligible to go in and get coverage wherever they may be, if they move from one place to another.

In other hearings, we have heard a lot of criticism of the regional alliances which are supposed to assure this portability of coverage from one geographic area to another. The health insurers, the insurance brokers and others want us to discard the exclusive mandatory regional alliances in favor of multiple voluntary competing purchasing groups.

My question to each of you as you look at your population groups that you are bringing to our attention, do you think that the regional alliances as proposed by the administration will give portability in coverage to migrant workers or foster children or the homeless, as the administration argues, and second, what would be the implications for your populations of discarding the regional alliances as the insurance industry has proposed?

Mr. Diringer, why don't we start with you.

Mr. DIRINGER. Thank you, Mr. Chairman. I think the insurance companies' proposal to discard the alliances actually takes us in the wrong direction. While there are portability problems in the regional migration of families and whether in fact this Health Card, the Health Security Card will get you full services wherever you are, that is in question.

I think discarding the regional alliances just goes the wrong way. For one thing, it eliminates any of the blending of rates that for those farm worker families who do have Medicaid, that we won't have a blended rate going at the same rate being paid to all the health plans, thereby just ensuring discrimination against people who are of low income.

And at the same time, I think we will have an even more fragmented system than we have now, with no oversight, no ability to coordinate the plans. We would like to see it all move into a national scope plan rather than one that is more fragmented.

Mr. WAXMAN. Thank you.

Mr. Halfon?

Mr. HALFON. I also believe the suggestion by the insurance industry is moving in the wrong direction. Although the foster child population is a very mobile population, moving from home to home and oftentimes moving outside of a potential regional alliance, there are ways in which certain safeguards can be built into the system that allow for those kinds of transitions to happen. Specifically, relationships need to be struck between the alliances and child welfare agencies, so that children moving from one place to the other can be immediately plugged into services.

But I wouldn't discard the idea of regional alliances for many of the same reasons that my colleague here has suggested.

Mr. WAXMAN. Notwithstanding you.

Dr. Redlener?

Mr. REDLENER. Just briefly, I would also like to add to the last two comments that the alliances are at least necessary in terms of what the President is proposing for a couple of reasons. One is that the larger they are, the more we are going to be able to really ensure community rating. I think that is exceedingly important. To even suggest the notion of competing multiple alliances would almost certainly push people who are of low income or who have special needs into quote, unquote, special alliances which in essence are not competitive and put them in a really difficult situation.

It is important to note that the President's plan, in addition to suggesting the alliances, is also suggesting a very strong set of programs dealing with essential community providers. And what we are talking about here is that the alliances would be able to recognize the viability and effectiveness of provider systems that are specifically dealing with the populations we are talking about. I think those assurances are pretty much in the plan, and I think that I would really be very concerned if that infrastructure was disrupted.

Mr. WAXMAN. Dr. Nickey?

Mr. NICKEY. I have nothing further to comment on. I think it has been very carefully delineated. My thoughts are concurrent.

Mr. WAXMAN. When we talk about competition between health care plans, you are representing here today the groups that no one really wants to compete for; homeless, foster children, migrant health care families.

If we just let the market work the way a number of my colleagues would propose us to do, do you think that managed competition market forces would be the answer in any way?

Dr. Redlener?

Mr. REDLENER. The market forces with reference homeless children at least would be incredibly dangerous. In New York City when managed Medicaid became the process by which we were moving forward to encompass these populations, we had immediately the development of rather unscrupulous managed care systems that in essence invaded the homeless territory.

They were actually going to homeless shelters and welfare hotels signing up people in limited restricted access managed care plans so that when the family would move, which they did very frequently, to the next shelter slightly out of that district, they now had a Medicaid card that was useless because they were already tied into a particular plan.

Second of all, without a lot of safeguards, what happens is it is really in the economic best interests of the managed care plan not to deliver the health services. The immunizations, for example, of a child are now fairly expensive. So if the child doesn't show up for those services, that is money for the plan. That doesn't require an expenditure to actually deliver the goods. And that experience was borne out in Minneapolis and many other cities.

What I think is different about what the President is proposing is much, much more scrutinized, accountable kinds of plans and delivery services which could work. But depending on market forces alone would be an absolute disaster for the majority of children that I see.

Mr. WAXMAN. My time has expired. Do you want to respond?

Mr. HALFON. Just real quickly. On the competition issue and leaving it to the marketplace, I think for children in general, there are some great risks in that regard, in a couple of ways. One is that under the managed care and managed competition, there is a great deal of discretionary decisionmaking that is made by plans, and this is enshrined in the law under the sort of notion of medical necessity.

Plans are allowed to decide what is medically necessary, even though there is a large list of benefits, they make those decisions according to what economically is going to suit them. For taking care of an adult patient, for example, it will clearly be in their advantage to void certain kinds of preventive services, like screening to save money on treating people for coronary arteries and heart attack.

For children, there is going to be little incentive for these plans economically to provide developmental services, certain kinds of preventive services, because the kind of economic gain will not come to them during the time that these children are in those plans. Those kind of savings will come when you provide developmental services for children on the ledgers of the special education program. So that plan has no economic incentive to provide those medical services.

So it is going to be very important if we do move towards managed competition and these competing managed care plans have real safeguards put in so the kinds of incentives are put in place to move the plans in a way that they do have an economic interest to provide very essential services to children, especially those kinds of children.

As you mentioned, no one is competing right now for children in foster care. Largely the reason why they are not is because when children come to them, they have such a host of problems that it is—they would rather shove them aside. And that is why there is going to also need to be provisions made to develop special, regionalized kinds of programs that are very special for some of these high risk populations that won't fit nice and neatly into your generic managed care plans.

Mr. WAXMAN. Thank you very much.

Mr. Greenwood?

Mr. GREENWOOD. Dr. Halfon, I am particularly interested in your testimony about children in foster care because, back in the late 1970's, I was a foster care caseworker for a county children and youth agency. I would take the kids into care and apply for the M.A. Card and take them literally to the health care providers, including the mental health providers. I didn't have time to read all of the report you brought with you. I want to do that. But I had a slightly different experience than some of what was accounted for in your report.

For instance, what was listed as a major impediment to or an important impediment to children in foster care receiving health care was the delay in having them certified as eligible and getting the medical assistance card. My recollection was that their eligibility began the moment they were taken into care. We had it worked out that their eligibility began when they came into care; that you

could get an emergency number within 24 hours if you needed it; and the child could be taken to the physician or elsewhere for care immediately and within 30 days the bill could be submitted.

So there really wasn't any gap in service there. Have things changed since then?

Mr. HALFON. I have done a number of studies at those specific issues. I think one of the things you have to recognize is that children in foster care are covered under the Medicaid system, and we basically have 50 or more Medicaid programs in the country. In each State, States come up with different eligibility criteria. For example, in Chicago they make children immediately eligible, they declare them a family of one. They make them eligible immediately for Medicaid.

In other States, there are long delays in getting kids eligible, so they don't get the kinds of health care services they need. It varies from State to State. The eligibility currently for kids in foster care is a patchwork for different kinds of Medicaid requirements. Under title IV, some are eligible and some are not. I am sure you are aware of that.

It is partially the inadequate reimbursement rates. It is partially that we have done little to build systems for the children in this country, build together multi-disciplinary teams that include doctors, social workers, psychologists to come together to take these populations, be they foster children, migrant children. And the incentives have not been there in the Medicaid system.

We would like to see if we are going to reform the health care program, that we reform it from the needs of the population, not the needs of the insurance companies. In the needs of the population, they need more comprehensive, coordinated services that are friendly to them. We need to have those kinds of incentives in the plan to make sure that the funding is there for those essential community providers and the building of these kinds of networks so that kids in foster care aren't being taken to someplace where someone doesn't have a clue of what a foster child is or what their special needs are or the fact that a kid being very quiet and ill is not just being a good little camper, but is incredibly depressed and needs to be taken care of in that way.

Mr. GREENWOOD. It may be that I am learning that the 50 States have very different ways of responding to kids in foster care. I am more familiar with how Pennsylvania does it, which seems to be better than other States in many ways. Let me just propose another model.

What if the States and counties, instead of certifying the children's eligibility under medical assistance, were given the same proportionate Federal dollars and could use those dollars to go out and purchase a health insurance policy that would automatically cover all of the children from the moment that they were entered into care?

Mr. HALFON. I think that there would be some specific problems in terms of—who are you going to give that money to? Do you give it to the foster parent?

Mr. GREENWOOD. I think to the county, purchasing——

Mr. HALFON. The child welfare agency?

Mr. GREENWOOD [continuing]. A Blue Cross/Blue Shield policy that would cover its average population of children in foster care.

Mr. HALFON. There is both the coverage issue—I think they need to be universally covered, no matter what, but there is a delivery system issue also. Even with that Blue Cross card, they need to be able to get to see a kind of provider that knows what they have, and can deal with them adequately.

And for these special populations, generic kinds of health care providers, my colleagues, some of the best pediatricians, have great difficulty taking care of these kids.

Mr. GREENWOOD. I agree with that. I am not sure the Clinton plan will get us all the way there.

Thank you.

Mr. WAXMAN. Thank you. Mr. Kreidler?

Mr. KREIDLER. Thank you, Mr. Chairman.

Dr. Halfon, in your prepared statement you say over the past 10 years, the notion of medical necessity has been transformed from a physician-determined criteria for inclusion of a particular service to a health care plan determined criteria for exclusion of services.

Can you give me an example of that, and do you mean to suggest that the burden should be on doctors to show necessity of services, or on the health plans to show that they are not necessary?

Mr. HALFON. I think the point here is that, historically, when insurance law was initially developed, that the notion of medical necessity was put in there so that doctors, as—when they were dealing with insurance companies, that they could get services for their patients, irrespective of what was sort of covered so that there was a sort of a fail-safe mechanism. And that was in the era of individual doctor and patient relationships.

We are clearly moving over the last 10 or 15 years to plans in which we have lots of doctors and big panels and panels of patients, and what has happened in the insurance law, in the courts over the last 10 years. And I am not a lawyer, but this is what my lawyer and colleagues have informed me, is that during this time period, what we have seen is that the medical necessity issue has been sort of turned on its head, and rather than being used by doctors to get from the insurance company special treatment for their patient, even though it might not or might be in a gray area, what it is being used over and over again is by managed care plans as a way of excluding certain kinds of services for patients.

And what has happened is, as the contract law has changed under managed care, this whole notion of medical necessity has been used more as a barrier rather than as a door to welcome people in to get certain kinds of services when they need it under the physician's discretion.

Having worked a little bit in managed care plans, and having colleagues who work in managed care plans, they talk constantly about having the imposition from above, wanting to provide certain services to their patients and they can't because they are told administratively they can't do that.

Mr. KREIDLER. I have worked in managed care too, and it seems to me frequently it is providers getting together among themselves and saying, some of these services tend to be what certain individuals would think might be great services to offer, but as a group

of providers, even in pediatrics, they come to the conclusion of saying does everybody get to do what they want to do and what we can afford, or do we get to the point where we start to say, what is the best care that we can reasonably provide in this situation without letting people kind of go off and pick and choose their own services no matter what the cost; don't you agree?

Mr. HALFON. I absolutely agree. I am a big proponent of developing very effective services that are proven to be effective and efficient delivery of services, both getting the most bang for the buck and also making sure that you have an allocative efficiency for those who have the greatest need. I just don't want to see the medical necessity issue used as a barrier to stand in the way of improving the effectiveness of what we are doing and the efficiency issue.

Mr. KREIDLER. I certainly hope that means that managed care plans that are successful are those that take those into account, that make sure that consumers are involved along with providers in making those kinds of decisions. I think if that is the case, those will be the ones that will succeed financially in providing services that people really want.

Let me ask a question here, if I might, of you, Dr. Redlener. I am sorry that Mr. Bliley has left, because I wasn't too sure just exactly what point he was making relative to the Toronto hospital's closure, whether he was implicitly advocating the Canadian system for America or perhaps that spending 40 percent more than the Canadians do on health care is not enough.

But in any case, is his concern about rationing an important one in your mind? Would people you are concerned with be more concerned about that or about getting any coverage in the first place?

Mr. REDLENER. This is a very important question, actually. As far as the populations that I am concerned with specifically as a provider, what is key here is taking a benefits package that is comprehensive and effective enough to take care of their needs and is accompanied by the ability to get the enabling services and development of services to the underserved areas.

That, in a certain way, begs the question of rationing, because I am saying up front that I don't think I would come to a table to discuss what should be rationed for poor children or homeless children or underserved children or children in general, for that matter. I would be interested in establishing what it is we would like to try to achieve with them and finding a way to deal with costs associated with it. Whether those costs need to be aggressively or actively controlled, or whether other mechanisms would be put into place, that would keep the lid on the increases in cost that we might see from year to year.

The point about the Canadian system that I think is of particular note here, and I come from the position of having been a very strong advocate of the Canadian style single-payer until about a year ago. What I am concerned about is a tax-based system that would then be dependent upon particular revenues being allocated from the Federal Government every year to provide those services would be subject to enormous pressures from the economy, from various political perspectives, et cetera.

And I think that in fact what we are dealing with in the Health Security Act offers a much more rational and appropriate way to

deal with paying for health services through this employer-mandated approach.

So for the population we are dealing with, they in fact are better off served by this proposed mechanism.

Mr. WAXMAN. Thank you.

Mr. Brown?

Mr. BROWN. Thank you, Mr. Chairman.

Dr. Redlener, you mentioned the State's interests in maintaining flexibility in providing additional services to children with specialized needs. Expand for me how you would allow the States some flexibility while still meeting those needs.

Mr. REDLENER. What I am saying is that the President's proposal, probably like most proposals that would have viability in the legislative process, at some point we are going to be dealing with—the Congress will pass and hopefully the President will sign a Federal framework for health reform, whether it is exactly the President's plan or some modification of that.

That implies the States then will have some flexibility to deal with the 50 different kinds of State Medicaid programs and how far each State progresses with its own reform efforts.

The bottom line is that if we allow too much flexibility in how the States deliver on that Federal framework, that is to say, will we see the sufficient insurances that must be sustained in order to make sure that everyone does have access to the system, that the enabling services are there, et cetera, et cetera.

What I want to say was that we have to be very careful that we don't go too far with State flexibility so that, tomorrow, States will flex out of their responsibilities to ensure universal access.

Mr. BROWN. What kind of specific safeguards would you build into it to make sure that doesn't happen?

Mr. REDLENER. I think what we would want to require is that every State must submit a plan to the Secretary of HHS, for example, that would delineate very specifically how that State would include every single kind of special needs population in their plan to get not only coverage but access to care, and that there has been a reasonable approach to determining what enabling services are available, what new facilities grants programs might be available, and that the State plan is very explicit with a time line about when their homeless children, when the migrant families, et cetera, when all these populations will be included in the plan.

That should be subject to review in a very explicit way in the reform proposal. And I think that to the extent that we can recognize that some State legislatures may be more enthusiastic than others about how rapidly or efficiently they will cover the underserved, those are the kinds of things we need to be vigilant about and to make sure we have been explicit enough about in the reform bill.

When the political system changes—I can give you specific examples that probably are not appropriate to do here—but when the political system may change or goes in a different direction, what we find is much less enthusiasm in particular circumstances to include those underserved, and the first to go will always be the ones with the least voice and the least enfranchisement in the system.

So the ones that will get it first in terms of being excluded from the system will be the children, medically unserved, the homeless,

the kids on the border, whatever. That has been our history and we are going to hopefully try to avoid that by being explicit in the reform plan you will eventually pass.

Mr. BROWN. Dr. Halfon, you called for a national pediatric standard. You mentioned a national pediatric standard. Does the Clinton plan does go far enough in terms of standardization of benefits for children's preventive services, that sort of thing?

Mr. HALFON. The idea of a child standard of coverage is one in which, again, the specific developmental vulnerability of children, their dependency issues, and the difference in their morbidity, is taken into account. I think the Clinton plan addresses that, but I really think that what Congress needs to do is actually use this child standard as a metric and hold it up to the plan and say, are we taking care of children adequately?

That means, in terms of coverage, are the benefits adequate for children, not for the frail, elderly, not for the working man going to managed care, but for children.

Are our delivery systems adequate for children? Are our performance standards adequate for children? And I would say that at the present time, the performance standards for children are inadequate.

Providing quality assessment systems for children is very, very different than providing quality assessment for adults. For example, for most adults who have high morbidity, high prevalence, high tech conditions—heart attacks, gallbladders, strokes—it is very easy to know how a hospital is doing when they do the carotid ap-
pendectomy.

For a child, you don't have these high tech, high prevalence conditions. You have lots of high prevalence, low morbidity, low tech conditions. It is much more difficult to tell whether a child is getting proper asthma care or whether his ear infections are being taken care of or whether they have received adequate developmental assessments. So there needs to be special attention paid to those kinds of quality assessments and special attention to those safeguards.

That is why the idea of a child standard of coverage to be used as a metric to go through the plan and say are we actually dealing with these things adequately, I think, is vitally important. I would refer you to—there is an article that came out in November in the Stanford Law Review that goes through why we need this child standard.

Mr. BROWN. Thank you.

Mr. WAXMAN. Thank you very much, Mr. Brown.

Dr. Nickey?

Mr. NICKEY. I want to add something from a perspective of the border, Mr. Chairman. Thank you for the opportunity to speak again. This has been a very erudite discussion, and I would just tell you from the Texas Medical Association and its three allied medical associations on the border, our whole thrust is to care for patients.

It is a God given and terribly earned honor that we have to provide for patients.

One of the things that you alluded to, and I might amplify on for just a moment, if I may, is about undocumented individuals living

in America, and not providing them services. I would think that would be a big disservice, whether they be Canadians or Germans or Mexicans or El Salvadorans.

Not only would they then be a threat to themselves if we did not offer them immunizations in our public health clinic, they would be a threat to the community they live in. I would strongly suggest and hope that your committee would take back to Congress in general the idea that this needs very special consideration, Mr. Chairman.

Thank you very much.

Mr. WAXMAN. Thank you. I want to thank the four of you very much for your testimony. It has been very useful. I think we will be referring back to and sharing it with our colleagues.

Our next panel will focus on the impact of the President's health plan on Americans infected with HIV. Pedro Zamora is a person living with AIDS and is a member of a number of AIDS service and advocacy organizations. Christine Lubinski is Deputy Executive Director for programs at the AIDS Action Council.

I want to welcome the two of you to our hearing today. Without objection, your prepared statement will be a part of the record in its entirety. We would like to ask you to limit the oral presentation to no more than 5 minutes.

Mr. Zamora, why don't we start with you.

STATEMENTS OF PETER ZAMORA, AIDS PATIENT; AND CHRISTINE LUBINSKI, DEPUTY EXECUTIVE DIRECTOR FOR PROGRAMS, AIDS ACTION COUNCIL

Mr. ZAMORA. Thank you. My name is Peter Zamora and I am a member of the board of directors of the AIDS Action Council. I am also involved with a variety of other AIDS organizations, including the National Minority AIDS Council. I am currently living in Miami, Fla., and I came to the United States from Cuba during the Mariel boat lift in 1980. I am 21 years old and I am now a citizen of the United States. I am also a person living with AIDS.

I was infected with HIV when I was a freshman in high school. Like 30 percent of the approximately 50,000 men, women and young people living with AIDS, I have no health insurance. For me, the debate over health care is not an abstract one.

The plan that is ultimately passed by this committee and the Congress and signed into law by President Clinton may not take effect soon enough to prolong my life. But I sincerely hope it will mean no one else will have to go through what I have been going through.

For the past 2 years, I have been employed by a nonprofit agency who gives educational instruction services for people living with HIV. I have traveled throughout South Florida and across the United States speaking to young people in schools and community organizations about HIV and AIDS.

Unfortunately, over the past 6 months, my health has declined, and I now face a crisis of trying to live and work with my illness without what some would view as the privilege of health care.

Neither my employer nor I can afford health insurance for me. I was diagnosed with AIDS at the age of 17 when I was a junior in high school. My mother died when I was 14, and my father, who

works in construction, was not able to afford health insurance for me or for my four brothers and sisters.

My doctor and I have a very good relationship, and I trust her. It is very important for me since a study of long-term survivors of AIDS found that the one thing that all of the survivors had in common was a very good relationship with their health care providers. It is critical for me to be able to choose providers that I trust who have experience in treating people with HIV.

Until this fall, my physician was willing to accept a payment of \$100 a month for my medical care. But now my T-cells have dropped to 140, and my doctor needs for me to be able to pay for numerous tests and medication. I don't want to retire at the age of 21 so that I can go on SSI and become eligible for Medicaid.

I love my work, and it gives me the strength and the energy and motivation I need to keep fighting for my life. Even if I were to retire and go on Medicaid, my doctor does not accept Medicaid, and I would not be able to choose physicians who would be best for me.

With my low T-cell count, I need to be taking prophylaxis for PCP or pneumocystis pneumonia. I am allergic to Bactrim and must use Pentamidine, which is very expensive. It is critical that these life-prolonging treatments be made available and affordable.

For the past 6 months, I have suffered through chronic diarrhea. My doctor and I have tried many medications, but it continues. There is the possibility that I have a parasite, and my doctor would like to do a colonoscopy, but this procedure costs over \$900, and I don't have any way to pay for it. So I take Immodium, which totally stops my bowel movements, forcing me to go off the Immodium every 3 days and suffer through diarrhea for 2 days. I hope the diarrhea will not get worse, as I struggle to find a way to get the health care I need without giving up my work.

I believe health care is a right. My family and I fled Cuba to escape Castro's repressive regime. We traveled for 24 hours over rough seas, on an unsafe boat, filled beyond its capacity, to come to this country.

I remember being 8 years old and talking to my mother about why were we going to America. And she talked to me about freedom and about hope and about opportunity. She talked to me about wanting to live in a land where our lives were protected and where if we worked hard and did our best, we could succeed.

I often now wonder what she would think if she was alive. I have worked very hard. I was an honor student, star of my high school track team. My class voted me best all around and most intellectual. My dream was to go to college to become a doctor, and ultimately to live the American dream. But because I live with AIDS and without the right of health care, many of these hopes have been dashed for me.

Please help us. Please resist the pressure to cave in to those who profit from the status quo. Pass the President's health care reform proposal. It guarantees coverage for me and the millions of other Americans with AIDS and other chronic illnesses and it guarantees a core benefits package that will make a profound difference in my life.

A reformed health care system will allow me to work, to be a productive citizen, and to live the American dream.

Thank you.

Mr. WAXMAN. Thank you very much, Mr. Zamora.

Ms. Lubinski?

STATEMENT OF CHRISTINE LUBINSKI

Ms. LUBINSKI. AIDS Action Council serves as the Washington representative for over 1,000 community-based organizations providing services to people living with HIV and AIDS. We believe that national health care reform is a national imperative and is the single most important issue on the agenda. It is always an honor to address this subcommittee, Mr. Chairman, given your uncompromising leadership on behalf of people living with HIV and AIDS in America.

Over a million Americans are living with HIV infection. These individuals live and die in every region of the country, in rural, urban, and suburban communities, and reflect every race and ethnic group in the Nation. Since 1981, over 350,000 men, women, and children have been diagnosed with AIDS. Over 200,000 of the total have died. We will never know how many of these individuals died prematurely or experienced unnecessary suffering because of the failure of our health care system to provide an appropriate level of management of HIV disease.

It is a truism in the HIV community that the American health care system is in crisis. It is our firm belief that any national health care reform plan enacted by Congress can be judged by its responsiveness to the needs of Americans living with HIV and AIDS, because living with HIV disease presents a broad spectrum of health needs.

From the provision of antiviral and prophylactic prescription drugs to keep people living with HIV healthy, to acute care for opportunistic infections, to home-based, long-term hospital care, people with AIDS are poorly served by the medical system. Forty percent are Medicaid recipients and 30 percent are uninsured.

Even for those who are insured, discrimination by insurers, caps on overall care for AIDS treatment, preexisting condition exclusions and a range of other common insurance practices make obtaining health care a frustrating, financially debilitating and sometimes life-threatening experience.

Since the beginning of the epidemic, the HIV community has pushed for fundamental reform and we salute President Clinton for the leadership and commitment which is reflected in the Health Security Act.

In our view, only the Health Security Act and the McDermott single-payer plan give reasonable hope to people living with AIDS for increased access to affordable health care. My written testimony outlines in some detail the strengths of the Health Security Act and the range of improvements we feel are urgently needed to the benefit package, affordability provisions, anti-discrimination and choice. But my few minutes before you will better serve Americans living with HIV and AIDS if I underscore the fundamental elements in the Clinton plan which must be maintained in this committee's reported bill if reform is to be meaningful.

It is imperative that the principle of universal coverage identified by President Clinton as a bottom line not be confused with univer-

sal opportunity to purchase coverage for those wealthy enough to afford it. Legislative phase-in schemes which make universality contingent on future financial and political exigencies are not acceptable. The Clinton plan's 1998 target for universal coverage must be nonnegotiable and already comes too late for hundreds of thousands of Americans living with AIDS who will never live to benefit from it.

Universal coverage means there must be true community rating across the widest possible pool of consumers. Individuals cannot finance the system alone. Employers must make a significant financial contribution and government must provide financial subsidies for unemployed and low-income individuals and families regardless of employment status.

Universal coverage means open enrollment in all plans and no preexisting condition exclusions. It means complete portability of coverage. The employment status of people living with HIV and AIDS changes as their illness changes and progresses.

It is now commonplace for people living with HIV and AIDS to choose not to work to access health care through the Medicaid program. A guaranteed comprehensive benefit package must be legislated. The Health Security Act outlines a comprehensive benefit package and contains elements critical to people living with HIV and AIDS, like prescription drug coverage, including off label use, mental health and substance abuse services, hospice care and home and community-based, long-term care, all of these health care services are basic for people with HIV and AIDS and other chronic illnesses.

A benefit package without prescription drug coverage, for example, would deprive AIDS patients of a benefit vital to the quality and duration of their lives. Access to quality care must be available to the poor as well as to wealthy Americans and to the chronically ill and disable as well as those of us in good health. Premium caps and limits on copayments and out-of-pocket maximums are critical and must not be abandoned and rather enhanced and improved.

There has been a great deal of talk about choice but too little discussion about the relationship of choice, affordability, and quality care. All health care providers do not have expertise in treating HIV disease and there is ample documentation about providers unwilling to treat patients with AIDS.

People with AIDS must be able to choose providers with compassion who have HIV expertise on their staff. Expensive premiums present a barrier to low-income patients with chronic illnesses. So we are concerned about the subsidy scheme which caps subsidies at the cost of the average cost plan, because it reduces the choices of low-income sick people to choose a plan with the resources they need.

We must have anti-discrimination protections. The structural changes in the health care delivery system proposed in the President's plan, including risk adjustment by disease and socioeconomic status, are critical and will reduce but not eliminate incentives to undertreat sick people. So we are convinced that anti-discrimination and confidentiality protections must be explicitly set out in the law and enforced in practice.

The claims of those who benefit from the status quo that the American health care system is not broken ring untrue. The system is broken. The Health Security Act would make health care a right rather than a privilege reserved for the healthy and affluent. We urge this committee to support meaningful health reform legislation by passing a bill which includes the Clinton plan's guarantees of universal coverage, a guaranteed benefit package, improved affordability and choice provisions and anti-discrimination and confidentiality protections.

Thank you very much.

[The prepared statement of Ms. Lubinski follows:]

**TESTIMONY OF CHRISTINE LUBINSKI,
DEPUTY EXECUTIVE DIRECTOR FOR PROGRAMS,
AIDS ACTION COUNCIL**

Thank you for offering AIDS Action Council the opportunity to testify before you today regarding the impact of President Clinton's Health Security Act on people living with HIV/AIDS. AIDS Action Council serves as the Washington representative for over 1,000 community-based organizations providing services to people living with HIV/AIDS. Since 1983, AIDS Action Council has been exclusively devoted to advocacy for effective national HIV/AIDS policy. In that role, we have seen first-hand the devastating failures of our current health care system, and believe that health care reform represents one of the most important pieces of federal legislation ever for people living with HIV/AIDS across this nation.

INTRODUCTION

Over a million Americans are living with HIV infection today. These individuals are living -- and dying -- in every region of this country, in rural, urban and suburban communities. The faces of people living with HIV/AIDS are the faces of America; tragically, there is no racial, ethnic, age or gender group in this nation that has not been affected by this epidemic. Since 1981, over 350,000 men, women and children have been diagnosed with AIDS in America. More than 200,000 of the total have died. We will never know how many of those individuals died prematurely or experienced unnecessary suffering because of the failure of our health care system to provide appropriate medical management of HIV disease.

People living with HIV/AIDS are poorly served by the current system. Forty percent of people with AIDS are Medicaid recipients and at least 30 percent are uninsured. Even for those who are insured, discrimination by insurers, caps on overall care for AIDS treatment, pre-existing condition exclusions and a range of other common insurance practices make obtaining health care a frustrating, financially debilitating and sometimes, life-threatening experience for Americans living with HIV/AIDS.

It is a truism in the HIV community -- people living with HIV/AIDS, their families and friends, service providers and other advocates -- that the American health care system is in crisis. It is our firm belief that any national health care reform plan enacted by the Congress can be judged by its responsiveness to the health care needs of Americans living with HIV/AIDS, because HIV disease presents a broad spectrum of health care needs -- from the provision of antiviral and prophylactic prescription drugs to keep relatively healthy people living with HIV healthy, to acute care for opportunistic infections, to home-based, long-term, and ultimately hospice care for those in the end stages of the disease.

Since the beginning of the epidemic, the HIV community has pushed for fundamental reform. We salute President Clinton for the leadership and commitment which is reflected in the Health Security Act.

I want to talk to you today about the fundamental elements of the Administration's Health Security Act which must be preserved by the Congress if national health care reform legislation is to be meaningful to Americans living with HIV/AIDS. In doing so, I will also be taking this opportunity to mention some things in the Health Security Act which we believe need to be

strengthened. I want to say at the outset, however, that we have reviewed many of the plans pending before Congress, and that although we believe there are areas of the Clinton plan that need to be strengthened, we are convinced that none of the other plans (with the notable exception of the McDermott single payer plan) offer the American people meaningful reform.

UNIVERSAL COVERAGE BY A DATE CERTAIN

It is imperative that the principle of universal coverage, identified as one of President Clinton's "bottom lines", be a bedrock for health care reform. Universal coverage must not be confused with merely a universal opportunity to purchase coverage for those healthy and wealthy enough to do so. We have that now, and it is why there is a health care crisis in this country. Universal coverage must apply to everyone at the same time -- legislative phase-in schemes which make universality contingent on future financial and political exigencies are schemes which do not in fact guarantee universal coverage. The Clinton plan's 1998 target for universal coverage must be non-negotiable. Even that will come too late for hundreds of thousands of Americans living with AIDS who will never live to benefit from it.

Universal coverage requires true community rating, across the widest possible pool of consumers. Universal coverage means coverage that is not solely dependent on individuals to finance the system alone. Employers must be required to make a financial contribution if universality is to be real. And government must provide financial subsidies for the unemployed and for low-income individuals and families, regardless of employment status.

When we talk about universal coverage, we mean that all Americans must be allowed to enroll in whatever plan meets their needs, and not be prevented from choosing a plan because of their health status or because of pre-existing condition exclusions.

Universal coverage means complete portability of coverage. The employment status of people living with HIV/AIDS changes as their illness changes and progresses. People with HIV/AIDS and other Americans with chronic illnesses and disabilities should have the opportunity to work without jeopardizing the ongoing health care services so vital to their functioning and well-being. It is now commonplace for people living with HIV/AIDS and other chronic illnesses to find themselves forced to choose between working and getting health care; because their employers and/or insurers will not provide health care coverage, they are forced to impoverish themselves to get into the Medicaid program.

President Clinton's Health Security Act contains these essential components of universal coverage. We have several concerns, however. For example, while we commend the Administration for including an employer mandate in its proposal, we fear that the current provisions regarding corporate opt-out for employers of 5000 or more could threaten the financial stability of the reformed system, especially if the threshold for opting out is lowered. The corporate opt-out will create corporate pools of healthy, young, generally higher-income

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individuals, and turn the state alliance system into a high-risk pool of the poorest and sickest, thus shifting costs back to the states and public/non-profit health providers. Even with the required corporate contribution to the regional alliance system, we believe the corporate opt-out provision may undermine reform.

We are also concerned that neither undocumented persons nor incarcerated individuals are included in the definition of "universal coverage" in the Clinton plan or any of the other proposals under consideration.

These concerns underscore the vital importance of preserving and expanding current federal and state programs which provide basic health care services to populations with significant rates of HIV infection. Until we are sure of the effects of health care reform, we must keep the critical safety net programs in place. I will discuss those programs more fully later in my testimony, but want to turn now to the issue of the comprehensive benefits package.

GUARANTEED COMPREHENSIVE BENEFITS PACKAGE

A guaranteed comprehensive benefit package must be included in the health care reform measure passed by Congress. Guaranteed coverage in a plan that does not provide a minimum comprehensive set of benefits is meaningless. The nature of HIV disease and other chronic and disabling conditions requires access to a full range of health care services to ensure quality care. The Health Security Act guarantees a comprehensive benefit package which contains elements critical to people living with HIV/AIDS like prescription drug coverage including off-label use, mental health and substance abuse services, hospice care and home and community-based long term care. All of these health care services are essential for people with HIV/AIDS. A benefit package without prescription drug coverage, for example, would deprive AIDS patients of a benefit vital to the quality and duration of their lives.

AIDS Action commends the Administration for guaranteeing a comprehensive benefit package that includes these key elements. However, we feel strongly that improvements must be made in this benefit package if it is to truly provide the basic health care services people with HIV/AIDS need.

Recommended Improvements in the Health Security Act:

Prescription Drug Coverage

- Create a drug formulary at the national level to ensure that coverage would be consistent regardless of plan enrollment or geography.
- Include coverage for investigational treatments for life-threatening conditions outside of clinical trials.

Mental Health and Substance Abuse Services

- Separate coverage for mental health services and substance abuse treatment so that individuals don't have to choose to receive coverage for one or the other of these conditions.

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- Eliminate the swapping arrangement in the mental health and substance abuse benefit between inpatient care, intensive outpatient services and outpatient services which undermines access to a continuum of care.
- Make copayments for mental health services and substance abuse treatment equal to copays for other health services and count all payments for these services toward the out-of-pocket maximum.

Home and Community-based Long Term Care Services

- Modify eligibility criteria to enable people with AIDS and other terminal illnesses who are in the last 24 months of life to access this humane, cost-effective alternative to acute care hospital placement.

Preventive Services

- Add HIV counseling and testing (age 13 and above) as a preventive benefit apart from the deductible with no copayment.
- Increase the frequency of PAP smears covered under the preventive benefit.

AFFORDABILITY AND CHOICE

Access to quality health care must be available to poor as well as to wealthy Americans and to the chronically ill and disabled as well as to those of us in good health. Therefore, it is critical that components of the Administration's proposal regarding premium caps and limitations on copayments and out-of-pocket maximums not be abandoned by the Congress, but rather enhanced and improved.

There has been a great deal of talk about "choice" in the health care reform debate so far, but too little discussion about the relationship between choice, affordability and quality care. All health care providers do not have expertise in treating HIV disease. Moreover, there is ample documentation to show that far too many health care providers are unwilling to treat patients with HIV/AIDS. People with HIV must be able to choose plans that have compassionate providers with HIV expertise on staff. Expensive premiums present a barrier to low-income individuals with chronic illnesses like HIV from choosing the plan most likely to meet their medical needs. While we commend the President's plan for integrating Medicaid recipients into the mainstream health care system and guaranteeing the same benefits package for all Americans, we are concerned that the subsidy scheme in the Health Security Act which caps subsidies at the cost of the average cost plan reduces the choices of low-income sick and disabled people to choose a plan with the staff and resources they need.

Recommended improvements in the Health Security Act:

- Allow full subsidies for low-income disabled individuals, including Medicaid recipients, to choose higher cost plans with providers competent to address their special needs.
- Allow full subsidies for individuals and families up to 150 percent of poverty; implement a sliding fee scale for people from 150 to 200 percent of poverty.
- Cap premium expenditures at 3.9 percent of income for any plan selected by people earning \$40,000 or less (not just up to the average cost plan).

- Pro-rate out-of-pocket payments on a monthly basis so that people with chronic illnesses like HIV/AIDS will not be faced with having to pay the entire out-of-pocket maximum in a month or two.

PRESERVATION OF VITAL PUBLIC HEALTH CATEGORICAL PROGRAMS

The Administration's bold plan to integrate all Americans, including poor individuals and other traditionally underserved populations into the mainstream health care delivery system is a laudable, but untried goal. From the perspective of the HIV community, it is imperative that federal safety net programs, including the Ryan White Care Act, the substance abuse block grant, federal tuberculosis initiatives and federally-funded HIV prevention programs remain intact during the transition to national reform and until it can be clearly demonstrated that the health alliances can provide the services currently provided by these programs. Many of these programs provide services which will not be available through the health care system. Case management and adult dental services are just two of the services currently provided under Ryan White which will not be available through health plans. The substance abuse block grant is the primary source of funding for long-term community based residential care for drug dependent persons, including women with dependent children. The substance abuse benefit simply will not provide services of that duration or intensity of care and it would be short-sighted to finance the substance abuse/mental health benefit with federal substance abuse block grant funds. AIDS Action will work to preserve and enhance funding for public health programs critical to the well-being of persons living with HIV/AIDS.

ANTI-DISCRIMINATION PROTECTIONS

Perhaps no group of Americans has experienced the tragic effects of discrimination in the health care system as acutely as people living with HIV and AIDS. We believe that any efforts to reform the health care system in this country will fail if guarantees of anti-discrimination are not explicitly set out in the law and enforced in practice. The incentives to deny health care coverage to Americans on the basis of their health condition, socio-economic status, race, or gender, particularly in managed care systems, will continue to exist, whether overtly or not, even if the essential elements we have spoken about today are included in health care reform.

Insurers and health care providers have significant financial incentives to deny health care coverage to sick people. Structural changes in the health care delivery system as proposed in the President's plan, including risk adjustment by disease and by socioeconomic status for payments to providers, are critical to substantially reducing, if not eliminating, these incentives. Nevertheless, given the widespread discrimination faced by individuals living with HIV/AIDS and other illnesses, we are convinced that health care reform efforts will fail if guarantees of due process, confidentiality of medical records, and anti-discrimination are not explicitly set out in the law and enforced in practice.

We commend President Clinton for including provisions in the Health Security Act that will ensure that Americans are given meaningful due process rights to appeal wrongful denials of

care. We commend the President for including provisions to prohibit discrimination based on health care condition, socio-economic status, race or gender; discrimination that for far too long has prevented people with HIV/AIDS from getting appropriate and affordable health care. However, we do have concerns regarding issues such as the potential for redlining, the lack of clarity regarding burdens of proof in discrimination cases, and the lack of specificity regarding the National Health Board's review of state plans for compliance with the anti-discrimination and consumer protection requirements in the Act.

We further commend the President for recognizing the importance of assuring all Americans that their medical records will be kept confidential, and for providing that data collection for utilization reviews, quality assurance and report card programs, and other purposes should only utilize blinded, aggregate data. These confidentiality protections are essential to ensuring that all Americans are protected from discrimination. Again, we do have some concerns about the lack of specificity regarding the National Health Board's review of state plans for compliance with these protections. We fear that misuse of data could result from the potential failure of the National Health Board to promulgate adequate, comprehensive standards for health data systems prior to the approval of any state plan. Despite these concerns, we believe that the President's plan is an enormous step in the right direction and we are committed to working with the Administration, Congress, and other consumer groups to address these concerns.

CONCLUSION

Health care reform is one of the most important pieces of federal legislation ever to come before the Congress. The claims of those who benefit from the status quo that the American health care system is not broken ring untrue to the millions of American families affected by HIV/AIDS. The system is broken, and we must fix it. The Health Security Act of 1993 would make health care a right, rather than a privilege reserved for the healthy and affluent. The promise of the President's proposal, to provide all Americans with comprehensive, affordable and appropriate health care by 1998, must be realized. We urge this Committee to support the Clinton plan's guarantees of universal coverage, a guaranteed comprehensive benefits package, affordability, and protection from discrimination, for the sake of all Americans.

Mr. WAXMAN. Thank you very much for your testimony, Ms. Lubinski.

I want to thank you both very much for your testimony.

Mr. Zamora, you have given us additional insight because, as you said, this is not an academic subject, it is a very personal one. And hearing from you and what you are going through, I think is a further reason why we need to adopt a plan that will give people the coverage that they need, even though it may not be available for you and so many others that are now struggling to fight the HIV and AIDS epidemic.

Let me ask you both this question: Obviously the biggest problem for people who have severe illnesses is the preexisting condition that insurance companies use to exclude those people. And the fact that not only are there preexisting conditions, but they have individual underwriting. If they think you are a high risk for other reasons, even if you didn't have a preexisting condition, insurance companies discriminate, even to the point of not providing coverage or sometimes charging a lot more for the coverage.

If we reform the insurance system, why wouldn't that be enough for people with HIV and AIDS? Wouldn't they then be able to buy insurance coverage without the necessity of having a whole universal coverage mandate on employers and more taxes for taxpayers to pay in order to subsidize them?

Ms. LUBINSKI. Well, I think there is no question in our minds that eliminating preexisting condition exclusions is critical. But it is not enough. We have to be able to—we must have community rating, which is to say we must have a risk pool that is large enough so that it reduces the financial disincentives of people to provide coverage to people with AIDS.

Yes, they won't—without preexisting condition exclusions, it seems to me, and without further reform of the system, you have a situation where, yes, the coverage is available to individuals living with HIV and AIDS, but simply not at a level possibly affordable to them. And if it is not affordable, it is not universal coverage. And I think that was part of the point I tried to make about the difference between universal access and universal coverage. So eliminating preexisting condition exclusions is just not enough.

Mr. WAXMAN. So if we are going to provide universal coverage as opposed to access, simply saying you can buy it if you can afford it, but if you can't afford it, you just go without, which, by the way, is a form of rationing.

Mr. Bliley showed a film of Canada where they are rationing, but we have rationing in this country when millions of people don't have access to health care because they don't have coverage that either is available to them or affordable for them. But if we provide for universal coverage, we have to pay for it. And there are three ways to do it; either the government picks up the tab through a tax system and then pays for everybody to be covered, or we build on the existing system where employers pick up a substantial part of the cost for their employees, or another idea that is being recommended and I am not even sure still how it would work, is to have individuals responsible for covering themselves. And if they still can't afford it, I don't know what you do to people who can't

afford to pay for it without some subsidy. Of course, that subsidy would have to be taxpayers' funds.

Given those three options, do you think the President's proposal will get us to where we want to go?

Ms. LUBINSKI. Well, I think it is fair to say that many in the HIV community feel like the single-payer system is the best way to go for us. But we are also politically realistic and there is an urgent need for some change in the system now. So in that context, I don't think there is any doubt in our mind that employer—without an employer mandate, none of this is meaningful, without a huge number of people contributing into the system, contributing for those healthy as well as those who are ill, those who make high salaries as well as those who make low, you are not really talking about making coverage real. So we see the employer mandate and a significant employer contribution as critical.

We are a little alarmed about recommendations that that contribution go below the 80 percent proposed in the President's plan, to 50 percent, because then the question again becomes for us, will individuals be able to afford those premiums?

Mr. WAXMAN. Now, if we have a benefit package, do you think HIV counseling and testing should be included as a prevention benefit, and do you think imposing costs on these kinds of services will discourage people from coming in and getting the testing and the counseling?

Ms. LUBINSKI. Well, I don't think there is—we strongly believe that HIV counseling and testing ought to be part of the preventive benefit plan without having to pay a copayment or a deductible. However, we feel it is unlikely that any of these plans will be able to offer anonymous testing, so we believe that the current CDC-funded HIV testing sites must also be preserved. But I don't think there is any question that cost is always a disincentive, particularly to having a diagnostic test. So we think it should be an integral part of the preventive health service benefit.

Mr. WAXMAN. Thank you very much.

Mr. Greenwood.

Mr. GREENWOOD. Thank you, Mr. Chairman.

Mr. Zamora, I would like to let you know that I admire you and I want you to know how courageous I think you are to come here and to tell your story, to place yourself in such a position of vulnerability before the country, as you are here. And I thank you for doing that.

I don't know whether we really need to change the entire health system of the country in order to solve your problem. I do think that what certainly needs to change is the notion that you should need to quit your job, to leave your employment, to stop being a productive, taxpaying citizen in order to avail yourself of the health care that you need.

And I would like to follow up with either/or both of you on the discussion that the chairman was just engaged in with regard to community rating and prohibition against exclusions. And what I heard Ms. Lubinski—am I saying that correctly?

Ms. LUBINSKI. Yes.

Mr. GREENWOOD. What I heard you say was that prohibiting the exclusions was not enough, if you simply had a result that the cov-

erage is available but not affordable. But isn't combining that with community rating so that your insurance, Mr. Zamora's insurance, and my insurance all cost the same if we live in the same region, regardless of our preexisting conditions? Don't those two in combination go most of the way, if not all of the way, to solve Mr. Zamora's problem?

Ms. LUBINSKI. Well, certainly community rating is a key agreement—key ingredient for us. But we also need the guaranteed comprehensive benefit package. Because I think one of the other points that I tried to make in my testimony, and Pedro in his, was that if critical elements necessary to improve the quality and duration of your life are not available, then your health care needs aren't met. And in the case of people living with HIV, that really is the gamut of services representative in the benefit package.

It is substance abuse treatment, it is mental health services, it is a strong prescription drug benefit. I mean, in a whole range of States in the country, Medicaid will only pay for three prescriptions a month for people living with HIV. Now if that isn't health care rationing, I don't know what is. So there has to be a guaranteed benefits package as well.

There also has to be universal coverage by a date certain, from our perspective, particularly because of the urgency of people living with HIV and AIDS in obtaining health care that will improve the quality and duration of their lives.

Mr. GREENWOOD. OK. Those are all the questions that I have, Mr. Chairman.

I would like to make one editorial comment that probably is pointless, but I do it anyway whenever the discussion of health care as a right or a privilege comes up. In my view, it is neither. It is a benefit. Rights are things that are freedoms; the freedom of speech, the freedom to assemble, and so forth, those are rights. They don't cost my neighbor anything, they just permit me to have a liberty.

Health care is a benefit. And I think that we need to decide as a society to what extent we are going to provide that benefit and to whom and whether it is to all of us, and how we are going to pay for it. But I think it confuses the argument when we get into the notion of whether it is a right or a privilege. That is an editorial comment.

Mr. WAXMAN. The gentlemen still has time, so will he yield to me on that point?

Mr. GREENWOOD. Certainly.

Mr. WAXMAN. I think we make a mistake if we argue that it is a constitutionally protected right, the way we have a right to free speech. Those are protected rights that every individual has, even against the majority. But in our society, given our values, we say that every child should have an education, a right to an education, even if the public pays for it. Because we know that if we didn't educate the next generation, we would be incredibly shortsighted for the future of this country.

How can we as a society say that when people get sick, they won't get health care? It really is a right in terms of recognizing the dignity of individuals, not because the law requires it, but because our values as a country require it from a public policy per-

spective. Don't we as a Nation have that obligation to all of our people to make sure that we don't turn them away when they get sick; don't cast them aside when they get old and chronically ill? And how do we provide that in a way that is the most effective?

Everybody in this country, it is argued, anyway, gets some kind of health care. And 40 percent of those people who have AIDS end up on Medicaid, which is, I guess, available to them because they are then forced to sink into poverty or lose their jobs and lose their income, become eligible. But in that sense, isn't it a right?

The gentleman's time will be extended.

Mr. GREENWOOD. Well, perhaps some of this is semantical, but in my opinion, the problem that we get into when we refer to health care as a right is that there is something implicit in it that it is something that comes for free, that we each get to demand it, when in fact it is something that we have to decide as a society, as we have in public education, that this is a benefit that we are willing to pay for.

It just seems to me that in this debate when I have watched some of the national advertising that goes on, that this notion that, after all, health care is a right, seems to assume that it comes for free and isn't something that we each have to be playing a role in contributing toward in one way or another, whether it is through our own health habits, whether it is through our own financial contributions or willingness to work, and so forth.

Mr. WAXMAN. Thank you.

Mr. Kreidler.

Mr. KREIDLER. Thank you, Mr. Chairman.

I, too, want to commend you, Mr. Zamora, for coming forward to offer your testimony. I can only imagine what it would be like. And since I am older and I can think of my own kids being in a comparable situation, I would certainly hope that the recommendations you are making before the committee today are ones that are honored.

I would hope that we would be capable as a country to step up to this challenge. It is interesting to me that of the industrialized developed nations in the world, only South Africa and the United States have failed to recognize, whether we call it a right or a benefit, or whatever it is, that it may be an obligation of our society to look after each other. It is truly sad. And for decades now we have ignored the cost of health care and what it was doing to deprive increasing numbers of our citizens of quality health care, meaning that they were rationed in the most cruel, thoughtless fashion that could be imaginable. And now it is time to change that.

And what you suggested to the committee, which I certainly support, is that we need to make sure we do what other countries do, save South Africa, and control the escalating price of health care so that we can guarantee and give people the security of knowing it is there for them tomorrow, if they need it; the loss of a job, illness, no matter how tragic, won't deny them those benefits. So I commend you for coming forward and offering your comments.

Thank you so very much.

Mr. ZAMORA. Thank you.

Mr. WAXMAN. Mr. Brown.

Mr. BROWN. I have no questions.

Thank you.

Mr. WAXMAN. I thank both of you very much for your testimony. We will look forward to working with you as we try to shepherd this legislation through.

Our next panel will focus on the impact of health care reform on people with disabilities. Our witnesses are a family from Berkeley, Calif., Bernard and Anne McDonald Cacho and their son Philip, who has cerebral palsy. They are accompanied by Allen Bergman of the United Cerebral Palsy Association, and Burke Balch of the National Right to Life Committee.

I would like to ask our witnesses to come forward if they would.

We want to welcome you to the hearing today. We very much appreciate your coming. I think what you have to tell us will be helpful to us as we try to look at the fact that there are special needs for people in this health care area that we need to be mindful of.

Mrs. Cacho, why don't we start with you.

STATEMENTS OF ANNE McDONALD CACHO, ON BEHALF OF CONSORTIUM FOR CITIZENS WITH DISABILITIES, ACCOMPANIED BY HER HUSBAND, BERNARD, AND ALLAN I. BERGMAN, UNITED CEREBRAL PALSY ASSOCIATION; AND BURKE J. BALCH, NATIONAL RIGHT TO LIFE COMMITTEE

Mrs. CACHO. Thank you.

Good morning, Mr. Chairman, members of the committee. I am Anne McDonald Cacho from Berkeley, Calif. Supporting me this morning is my husband, Bernard Cacho, and my son Philip.

Thank you for this opportunity to testify about our experience in accessing health care for Philip. We hope to present a picture for your thoughtful consideration in order that the President's Health Care Security Act will truly provide lifetime health security for our family and the millions of families like ours.

We hope to speak for those families who you may not ever hear, see or know, because they are broken and silenced by the present system, who have not the voice, language, education, finances, or empowerment to have escaped the despair of trying to cope with extraordinary concerns in a health care system whose delivery I can describe in the politest of terms as "bizarre," and the most personal terms as "dangerously indifferent."

We are representing the Consortium for Citizens with Disabilities and United Cerebral Palsy Associations, Incorporated.

We would like to thank President Clinton for taking up this critical issue for all Americans.

Much as we might like to pretend that our family will somehow magically escape a medical crisis, this kind of collective denial serves no purpose than to perpetuate a society of "us" versus "them." One day we were "us"; the day after Philip's birth, asphyxia, we became "them." This is the real world, with real risks.

I am grateful and hopeful for your efforts to establish a health care system where the Cacho family is free to join the risk pool of humanity, rather than being confined to the risk pool of three, Anne, Bernard and Philip; one-third of the pool, Philip, who requires aggressive, attentive, long-term medical intervention, who no insurance company in the United States would touch with a 10-

foot pole, unless contractually bound to do so before Philip's condition existed.

Universal access is critical to families caring for a loved one with a disability. Security we could only dream about until now. The elimination of exclusions for preexisting conditions must be provided. Our horror stories with our insurance company, one of the largest in the United States, would make any person cut and run for their lives.

Tragically, for us, there is no one to run to. Coverage with no lifetime cap on benefits, coupled with a mandated community-rated premium, will mean the difference between financial impoverishment and maintaining a modest family lifestyle. Therefore, you must preserve these critical principles especially bodied in the President's Health Security Act.

Let me describe our lifestyle: Philip's care requires 24-hour-a-day, on-call, hands-on assistance by Bernard or me. Bernard takes care, while I work. One income is our family's choice, since the alternative, institutionalization, is not in our vocabulary.

I am self-employed. We are self-insured by Metropolitan Life Insurance Company. Our family health insurance premium has grown from \$270 per month in 1985 to \$902 per month in 1994; \$3,200 per year, to \$10,800 per year—\$10,800 per year. Although Met Life's exposure is quite limited, a \$50,000 maximum benefit per person, per illness, per year, secured on an exception basis, with surgeries and hospital stays tied to an antiquated cost schedule through the life of the policy.

Premiums have increased 334 percent in 8 years. Yet physical, occupational and speech therapy costs have gone from \$60 an hour to \$80 in that same time; 80/20 is the lifetime split.

A 100-percent threshold does not exist for us. In terms of our family then, the premium was 16 percent of family income in 1985; it is now 54 percent. Fifty-four percent plus out-of-pocket expenses, plus copayments. This is not health security.

In spite of our insurer's limited exposure, we have found it necessary to obtain attorneys on four different occasions to protect benefits in the contract and those protected by law. The most recent fee amounted to \$5,000 in 1993, and this battle lasted over a year, with reimbursements held pending outcome. Of course, premiums were duly collected throughout. We won, if that is the proper term to use.

How many families like ours tragically join the ranks of the uninsured through experiences such as ours? How many could not fight? How many?

I hope you haven't forgotten Philip's needs in all this. This is the most crucial element in our testimony. We have survived the torment of the present system and have researched possible escape routes, possibly selling our California home, moving to Wisconsin where life is cheaper, the care afforded children like Philip is exceptional, and the support extended to families under an extended Medicaid program is in line with the 1990's understanding of the type of care crucial to kids with disabilities, and that we all benefit by allowing families the security to enable them to care for the children they love. Sounds pretty OK then for us.

When these protections become a reality, we can breathe a sigh of relief. No. The reality is that the way the current Act is written, Philip and children whose medical needs stem from sometime between conception and birth, children with Down's syndrome, spina bifida, cerebral palsy, epilepsy, to name a well-known few, cannot escape their condition and will not be afforded health security.

To have done everything right, to have worked so hard, to have come so far, we and families like ours cannot weather this blow. By some twist of cruel logic or sanctioned indifference, an entire subclass of Americans has been created. This cannot stand. The ramifications are horrifying.

Let me touch on some of Philip's complex and preventive care needs, which we have fought long and hard for, which we stand to lose. We can furnish you with doctors' reports to explain these needs fully:

Number one, continuing physical therapy for the purpose of preventive rehabilitation to avoid progressive deterioration of his condition, hip dislocation, contractures, compromised lung function, pain.

Two, continuation of occupational and speech therapy for his feeding dysfunction, avoiding aspiration, related pulmonary complications, preventing the need for hospitalizations for pneumonia and gastrostomy surgery, and to learn the use of assistive technology for wheelchair mobility, verbal communication and writing, environmental control.

Three, durable medical equipment which allows Philip the freedom to interact with his surrounding world, perform the functions of bathing, toileting, and to prevent further deterioration of his hips.

Four, and of course, long-term care. Early in Philip's life, Philip's neurologist explained his CT scans to Bernard and I with tears in her eyes at his prognosis. This same doctor several years later could not believe this was the same child.

Lest America become the Romania of the West, fix this horrible omission of protection. Twisted bodies, throw away children, and hopeless lives are not defined at birth. They are made. They are made by applying—by not applying accepted and knowledgeable medical practices. They are made by gatekeepers who can live with themselves when choosing a dollar over quality of life. They are made when families are forced by a society that chooses to value the "us's," and not the "them's," to give up their own children in financial desperation.

How many of us wouldn't be outraged if a family gave up the normal sibling to foster care so that they could give the child with special needs the extra care he required? Or abort the normal fetus in the womb for the same reasons?

Our easy tolerance for these desperate decisions for children with disabilities speaks volumes. Please, don't tell me all men are created equal has become a cliché. Did Lincoln define a time window for equality? I think not. That would be unconscionable.

Thank you.

[The prepared statement of Mrs. McDonald Cacho follows:]

STATEMENT OF ANNE McDONALD CACHO

Good morning. Mr Chairman, Members of the Committee. My name is Anne McDonald Cacho. With me this morning is my husband, Bernard, and our son Philip. We are very pleased to be here with you this morning to testify about our experiences in accessing health insurance and health care coverage for Philip, how we will be effected by the President's Health Security Act and changes we believe will be necessary in the legislation for our family and millions of families like ours to truly have lifetime health security. We are here representing the Consortium for Citizens with Disabilities and United Cerebral Palsy Associations, Inc.

Although our horror stories with our insurance company began before Philip's birth and will be detailed in our written testimony, for today we will be concentrating on Philip's health care needs.

First, we would like to commend President Clinton for taking on this critical issue for all Americans. In terms of our family, the Health Security Act has a number of provisions which will make life tolerable for our family and which must be preserved in any health care reform legislation passed by Congress. Establishing a right to universal access to health care for all Americans is a critical foundation for all families with a member with a disability. The Health Security Act (H.S.A.) provides this. The Health Security Act also provides the security of no more exclusions for pre-existing conditions such as Cerebral Palsy, Down Syndrome, Epilepsy, Spina Bifida, etc. This protection cannot be removed. We need this if we are not going to continue to be held captive by our current carrier. No other carrier will pick up coverage for Philip because of his pre-existing condition. In addition, the Health Security Act provides coverage for health care expenses with no lifetime cap on benefits, which for a family like ours, when coupled with a mandated community-rated premium, in the H.S.A. will mean the difference between bankruptcy or financial impoverishment and maintaining a modest family lifestyle.

Let me be specific. I am self-employed. My husband has been Philip's primary care-taker for the past four years. Prior to that my husband was self employed and I was Philip's primary caregiver. We have a private health insurance policy with Metropolitan Life Insurance Co. We do not belong to an employer group. In 1985, our health insurance premium was \$270.00 per month or \$3240.00 per year. This year our premium has risen to \$902.00 per month or \$10,824.00 per year. To make matters worse, our policy only provides coverage of \$50,000.00 per year per person. Thus, the insurer's liability or exposure has not changed during the life of the policy while our premium has risen 334% over the past eight years. In terms of our family, the premium has gone from 16 % of our family income to 54 % of our family income in eight years. In spite of the insurance company's limited exposure, we have had constant battles with them over claim reimbursement with claims being denied, claims being lost and claims being disallowed as not

medically necessary or as "too pricey". We also have experienced extensive delays in payment of up to six months. We have had to obtain attorneys to assist us on four different occasions, the most recent legal fee amounting to \$5,000 in 1993. I cannot begin to count the hundreds of hours we have spent on the claims filing, tracking, appeals, copying records, etc. I can tell you that I have completely filled three file drawers in a standard four drawer office file to keep track of all of these issues. All of this to make sure that our son gets what he needs to have good health, optimal function and quality of life. This is not right. The Health Security Act will remedy many of these problems.

On the other hand, the Health Security Act takes away some coverage which we now have and have fought to retain; Philip's physical therapy, occupational therapy and his speech-language pathology therapy and services. Philip receives four hours of speech therapy, four hours of occupational therapy and six hours of physical therapy per week. The Health Security Act would deny Philip all coverage for these life essential therapies because in section 1123 (page 69), it defines Outpatient Rehabilitation Services only "to restore functional capacity or minimize limitations on physical and cognitive functions as a result of an illness or injury". This traditional acute care definition discriminates against all people whose disability originated before birth and, in fact, creates a new class of pre-existing condition exclusions based on the age of onset of disability. Is there really a difference between a child with cerebral palsy from birth and a child who nearly drowns or has viral encephalitis at six months of age and needs these therapies? I am confident that you will agree that there is no difference for the child or the family. Section 1123 also limits speech pathology services "for the purpose of attaining or restoring speech". Why? Philip needs speech/language pathology services for assistance and training in communication (alternative and augmentative communication) and for assistance in oral-motor stimulation essential to his eating which is the most essential prerequisite to life!

We also have similar concerns over the eligibility standard in the Health Security Act for Home Health Care in section 1118 (page 64). This definition again discriminates against individuals with disabilities from congenital conditions and is provided "only as an alternative to inpatient treatment in a hospital, skilled nursing facility, or rehabilitation facility after an illness or injury". Have we not yet concluded in 1993 that the institutional environments are the last alternatives for our children and family members when we have exhausted our home health care benefits and our families? We urge you to correct this language. Lastly in this area, the definition of extended care coverage in section 1119 (page 64) contains the same discrimination against individuals with disabilities that occurred prior to birth.

We also have concerns over the definition of durable medical equipment and prosthetic and orthotic devices in section 1124 (page 70). We admit that some of these items are expensive; however, the alternatives are much more expensive financially, emotionally and physically. For example, the seating inserts in Philip's wheelchair are essential for his proper seating and positioning. Without them he will develop dislocated hips and/or scoliosis (curvature of the spine) both of which will require major surgeries and hospitalizations. Philip waited for over a year for his seating inserts because our insurance company said they were too expensive. Mr. Chairman, please amend this section of the bill to ensure that Philip and all other individuals with disabilities have a right to the durable medical equipment and assistive technology such as computer with voice output in order to have maximum functional capacity as part of the definition of health. Moreover, we believe that for many individuals with disabilities the appropriate durable medical equipment and assistive technology perform a major function in the prevention of secondary disabilities. The President has placed an emphasis on primary health prevention which we support; however, for people with disabilities a critical health care benefit is the prevention of secondary disability and other health conditions.

Another issue of concern in the federally guaranteed benefit package of concern to the disability community is section 1122, the outpatient prescription drugs and biologicals benefit (page 67). (More to be added in final written CCD testimony) re: generic substitution and formulary issues.

Philip's medical care involves a large number of highly trained and competent specialists. We are very fearful over the implications of limited to no access to such specialists under a managed care system which the Health Security Act envisions for most Americans. Philip requires the ongoing involvement of his pediatrician, a pediatric orthopedist, a pediatric neurologist, a pediatric allergist and a pediatric rehabilitation specialist (physiatrist). These physicians are not frills or luxuries to Philip at the whim of a managed care gatekeeper. They are absolutely essential to his health care and there cannot be any financial incentives for his health plan or for us to not obtain these critical services as well as the highly trained and competent pediatric allied health professionals (therapists) which we discussed earlier. Please be sure that health care reform ensures that individuals with disabilities have freedom of choice and access to the specialists they need even within a managed care plan and with no additional out of pocket costs or higher copayments as the bill currently proposes.

Lastly, we would like to commend the President for including home and community based long term care reform in the Health Security Act. This component is compatible with work of the chairman in

developing the Medicaid Home and Community Based Waiver program in 1981 which has meant a great deal to over 100,000 children and adults with disabilities. This component is absolutely essential for health security for our family and millions of children with disabilities and their families and adults with disabilities. The President's plan makes significant policy changes here that have great potential for all Americans with disabilities and they must be preserved in the final legislation. The Health Security Act creates a new, non-Medicaid long term care program for all Americans regardless of age or disabling condition. It also mandates personal assistance services and mandated choice for either consumer directed or agency directed personal assistance (page 407). This provision is complemented by the payment for services section (pages 406-407) which allows a state to use vouchers, or cash payments directly to individuals with disabilities or their families. For our family to benefit from this long term care benefit these provisions must be available to us. For example, it takes us one and one-half hours to feed Philip each meal! When we used to get respite care services we found that we could not trust it because we were getting different people almost every time and they did not know our son. We need to be able to recruit, hire, train, and fire, if necessary, any home care support workers who will come into our family rather than deal with a home health care agency provider. There is, however, one major flaw with the new long term care provisions. There is no limit on out of pocket expenditures, which for a family like ours makes it unaffordable and will continue to mean that one of us will be Philip's primary caregiver. (More to follow in written testimony as well as comments on the tax credit for personal assistance services for working age adults and a recommendation for a comparable tax credit for families caring for children with severe disabilities at home.) You must impose affordable caps on long term care out-of-pocket expenses.

Thank you for your attention to our issues. We will be very pleased to answer any of your questions about what it will take to give our family the health security the President wants us to have.

A more extensive statement will be prepared for the written record and submitted next week. Due to inclement weather in the DC area over the last week it could not be prepared in time.

Mr. WAXMAN. Thank you very much, Mrs. Cacho, and Mr. Cacho and Philip, for being here today.

I want to ask you some questions, Mr. Bergman, but we have Mr. Balch on the panel, also, and I think he has some points that he wants to contribute, then we will ask you all questions together.

Mr. Balch, your prepared statement will be in the record. We would like to ask you if you would limit the oral statement to no more than 5 minutes.

STATEMENT OF BURKE J. BALCH

Mr. BALCH. Certainly, Mr. Chairman, though it is going to be very hard to speak after what we have just heard.

Mr. Chairman, the National Right to Life Committee opposes the administration's health plan for two equal reasons, only one of which I shall address today. We oppose it because it includes abortion, but at this hearing I shall discuss our opposition to rationing. The President's plan will necessarily mean rationing, including involuntary denial of lifesaving medical treatment.

This rationing will disproportionately impact the most vulnerable segments of our populace, people with disabilities and older people. Some of this rationing involves what is left out of the comprehensive benefits package. Most, however, will be rationing of treatment theoretically part of that package, that will be forced by the cost squeeze the plan would impose on American health care.

The benefits package denies vital care to people with disabilities. Section 1123(b)(1) limits outpatient rehabilitative services. First, they may be provided only to those who need them as a result of illness or injury. Children born with disabilities will be completely excluded.

Second, even for those disabled by illness or injury, rehabilitative services will be cut off after 60 days unless it is determined that function is improving. Those who need such services for maintenance of functioning, many people with cerebral palsy, for example, will be cut off.

Most rationing will be imposed by the cost controls. Under the administration plan, the value of health insurance Americans will be allowed to purchase will be limited by premium caps. These caps will be permitted to rise each year only at a rate far less than that of health care cost inflation. Therefore, each year the health plans will have less and less money in real terms, that is dollars adjusted for health care inflation. This gradual fiscal strangulation will force health plans to ration more and more each year.

The administration claims these caps will only cut waste and fraud, not cause rationing. But Robert Shiels of the respected econometric firm Lewin-VHS has pointed out that in order to maintain the current level of health care under the administration's premium caps, health care would have to achieve annual productivity increases five times those now seen in manufacturing.

As other economists, like William Baumol, Director of NYU's Starr Center for Applied Economics note, it is actually the other way around. Because health care is labor intensive, its productivity necessarily increases at a rate less than that of capital-intensive industries such as manufacturing. Section 5201(e)(3) specifically authorizes health plans to deny treatment within the comprehensive

benefits package whenever the treatment is, quote, "not medically appropriate," unquote.

On September 30, Hillary Clinton testified before the Senate Finance Committee that treatment is not appropriate if it, quote, "will not enhance or save the quality of life."

Given the strong prejudices against people with disabilities in our society, it is not surprising that medical personnel frequently judge the quality of life of those with disabilities as not measuring up to a cost benefit analysis. The use of the so-called "quality of life" criteria in the Oregon health care rationing scheme, which we strongly opposed, illustrates this.

Increasingly, such "quality of life" based denials of treatment are being directed against older people as well. While the administration plan would not fold all Medicare into the regional alliance system, as it does Medicaid, its plan still puts older people at extreme risk of rationing.

First, States could choose to fold in Medicare. Second, many older people exhaust their Medicare benefits and must resort to Medicaid; at that point, of course, they would be subject to the premium caps of the general system.

Third, the plan imposes drastic cuts in Medicare's ability to keep up with health care cost inflation. In the past, the effect of such cuts has been somewhat softened by cost shifting toward insured patients. Under the administration plan, that avenue will be cut off through premium caps imposed on virtually all other insurance.

The administration plan will in effect perpetuate a two-tier system in America. Only the very wealthy who have enough resources to pay for even the most expensive health care entirely on their own will be able to get adequate care.

In the second tier, subject to rationing, will be not only the poor, but also those in the middle class. This is because Americans will be forbidden to use our own money for supplemental insurance to protect our families from rationing. Section 1422 prohibits us from being sold supplemental insurance that duplicates any categories of treatment in the comprehensive benefits package. There is no exception for treatment within that package that is denied as "inappropriate" for a health plan because of a "quality of life" judgment.

Other features there is no time to discuss in oral testimony, such as the requirement of an annual decrease in the total number of doctors trained, specialist training would be cut almost in half, and limits on the ability to choose one's own doctor add to rationing in the administration plan. The National Right to Life Committee respectfully urges you to reject it.

Thank you.

[The following articles were submitted:]

DO HEALTH CARE COSTS MATTER?

By William J. Baumol

The exploding cost of health care is clearly a matter of concern across the industrialized world. In the United States the president has stressed this issue as one of the most critical facing us, arguing that soaring health care costs not only drain the economy, but price good health out of the reach of many Americans. The issue, it is important to note, is not just absolute levels of health care costs, but the *rate* at which they're rising and the growing share of the national economy they occupy. The reasons cited for this are many—from the greed of drug and insurance companies to an increasingly aged population. But there's also something else at work here: a deep economic force that suggests the relative increase in health care costs compared with the rest of the economy is an inevitable and ineradicable part of a developed economy. The attempt to do anything about it may be as foolhardy as it is impossible.

But first some facts. The relative rate of growth of health care costs is indisputable. From 1948 to 1992 the price of a doctor's services increased more than 5.5 percent a year, compared with an average annual increase of 4 percent in the Consumer Price Index. This gap may not seem very large for any one year, but over the forty-four years in question it means that the price of a doctor's services increased by more than 100 percent in real terms. In the same period, the price of a hospital room grew even more rapidly: by 700 percent in real terms.

In America the phenomenon has been worse than in other countries, but there is no other advanced country in which complaints about rates of cost increase are not heard. According to the latest Organization for Economic Cooperation and Development medical-consumption price index, in fourteen of eighteen countries in the years 1960 through 1990, health care prices rose more rapidly than prices in general. The U.S. rate of increase was exceeded by that in seven countries—Australia, Austria, Canada, the Netherlands, New Zealand, Norway and Switzerland.

WILLIAM J. BAUMOL is director of the C. V. Starr Center for Applied Economics at New York University. This article is based on a longer paper to be published by the American Philosophical Society.

Although in recent years the growth rate of U.S. costs has accelerated relative to that of the other leading economies (and the proportion of health spending here is still higher than in other countries), the universality and persistence of the problem suggest it lies deeper than the particular administrative or institutional arrangements adopted in any single country.

What, then, can its source be? There are many influences, actual or alleged. Lawsuits against doctors, lack of competitiveness in the profession and high earnings of physicians clearly help explain the *levels* of those costs. But I am aware of no source besides the one about to be described that seems to account for the many countries in which *growth* in health costs persistently outpaces the rate of inflation.

If litigation could explain the rise in medical costs, it, and the size of jury awards, would have to have been increasing throughout the last few decades. I know of no evidence that this was so, or that it was so in the other countries in which costs have been rising faster than ours. Recent evidence even seems to suggest that the pertinent litigation in the United States has been leveling off or declining. There has been no discernible trend in the size of jury awards, but the frequency of plaintiff victories has been declining, meaning that the total cost of malpractice awards has also probably been falling.

Similarly, if lack of competitiveness were the problem, the degree of competitiveness would have to have been falling over the years. The evidence, however, is to the contrary. The rapid growth in the number and membership of HMOs has added to the forces of competition. The number of physicians per capita has been expanding since 1960 and, with that, the pressures for doctors to compete for patients. Moreover, the proportion of applicants to medical school who are granted admission and the proportion of medical students who graduate have also grown. The other alleged cause of the relative rise of health care costs—doctors' incomes—also doesn't seem to explain much. Over the past fifteen years, the real earnings of doctors in the United States have been virtually constant. The 1991 *U.S. Statistical Abstract* reports the trends in median net physician incomes for the period 1973-1988. In 1988 real average physician income was somewhat less than

where it had begun, at \$53,600 in 1975 dollars.

Where, then, does that leave us? It is almost exactly a quarter-century since William Bowen and I first reported our analysis of what is now called "the cost disease of the personal services," including health care, education and a number of other services. A major source of the cost disease, we argued, was the different productivity growth rates of the various parts of a developed economy. Put simply, we noted that some parts of the economy—what we called the "stagnant services"—experienced consistently lower productivity growth rates than other sectors did. These services—notably health care, education, law, welfare programs, mail, police, sanitation, repairs, the performing arts and restaurant services—all had in common the handicraft attribute of their supply processes. None of them had been fully liberated from the requirement of a large residue of personal attention by their producers. Not that the growth rate of their labor productivity had been zero. In almost every case there was some productivity gain with the passage of time; but in the long run, it was far slower than the rate of productivity increase in the economy as a whole.

There are at least two reasons why this is so. First, these services are inherently resistant to automation. The manufacture of thousands of identical cars can be carried out on an assembly line, but the repair of a car just hauled to a garage from the site of an accident can not be entrusted completely to automated processes. Second, in many of these services, quality is, or is at least believed to be, inescapably correlated with the amount of labor expended on their production. Doctors who speed up the examination of their patients, or police forces that spend less time on the beat, are held to be shortchanging those they serve. This has a real effect on the relative share of GNP and relative sector labor costs that exist in an advanced economy.

To see why, imagine an economy divided into two sectors: one, the progressive sector, in which productivity is rising, and another, the stagnant sector, in which productivity is constant. Suppose the first economic sector produces cars, and the second, performances of Mozart quartets. Assume that in car production, where technological improvements are possible, output per work-hour is increasing at an annual rate of 4 percent, while the productivity of quartet players remains unchanged year after year. Imagine now that the workers in the car industry recognize the growth in their own productivity and persuade management to agree to a matching rise in wages. The effect on the auto industry is easy to trace. Each year the average worker's wages go up by 4 percent, but her output increases by exactly the same percentage. Then the one effect on cost is exactly offset by the other—total cost and output both rise 4 percent. So labor cost *per unit* (the ratio between total labor cost and total output) remains absolutely unchanged. This process can continue indefinitely in our imaginary world, with auto

workers earning more and more each year, with cost per car remaining stationary, and with no rise in car prices necessary to maintain company profits.

But what of the other industry in our little economy? How is quartet performance faring in this society of growing abundance? Suppose that the quartet players somehow succeed in getting their wages raised, and that their standard of living, though below that of the auto workers, maintains its relative position, also increasing 4 percent per year. What does this situation imply for the costs of quartet performance? If the earnings of string players increase by 4 percent per year while their productivity remains unchanged, it follows that the direct labor cost per unit of their output must also rise at 4 percent, since cost per unit is equal to total cost divided by the number of units of output. If in a forty-hour week the string player provides just as many performances as he did the previous year but his wage is 4 percent higher, then the cost per performance must have risen correspondingly. Moreover, there is nothing in the nature of this situation to prevent the cost of performance from rising indefinitely and at a compounded rate. So long as the musicians are successful in resisting erosion of their relative incomes, the cost per performance must continue to increase along with the performers' income. Cumulatively rising costs will beset the performing arts with absolute inevitability.

It is important to recognize that ordinary price inflation plays no role in the logic of our analysis. That is, as long as the wages of musicians in this two-sector economy continue to increase at all, the cost of a live performance will rise, cumulatively and persistently, relative to the cost of a car, whether or not the general price level in the economy is changing; the extent of the increase in the relative cost of the performance will depend directly on the relative rate of growth of productivity in the car industry. Moreover, though it is always tempting to seek some villain to explain such a run of real price increases, there is no guilty party here. Neither wasteful expenditure nor greed plays any role. It is the relatively stagnant technology of live musical performance—its inherent resistance to productivity improvements—that accounts for the compounding rise in the cost of performance of quartets.

It's clear how this analysis applies to the relatively increasing cost of health care. Clearly, health care has taken giant steps in quality improvement over the decades, but while the amount of physician time spent per patient visit or per illness may have declined somewhat, it has done so only marginally. Even the most elaborate technology needs to be applied patient-by-patient in a painstakingly labor-intensive fashion. The upshot is that this service must suffer from a rise in its cost that is terrifyingly rapid and frighteningly persistent. It threatens the strained budgets of individual families, as well as of central governments.

Is there a way out of this morass? The bad news is: unfortunately not. The good news is: on closer inspection, the morass is not as depressing as it first looks. In

truth, the very structure of the problem is such as to offer society all the resources for its solution. We can afford ever more ample medical care, ever more abundant education, ever more adequate support of the indigent, and all this along with a growing abundance of private comforts and luxuries. This conclusion may sound implausible in light of all that has been said. But it's inescapable, if only our future productivity record bears any resemblance to that of decades past, which brought us ever better health care, despite rising costs. There are two fundamental reasons why this must be so.

The small, but positive, productivity growth rate in the stagnant services. In *A Connecticut Yankee in King Arthur's Court*, Mark Twain devotes an entire chapter to Sir Boss's unsuccessful bid to explain the concept of real wages to his primitive hosts. He argues passionately that the monetary magnitudes of wages are irrelevant; that, regardless of their value as expressed in terms of money, wages are really higher only when it takes fewer hours of labor to earn the wages needed to purchase a given set of goods. Yet, precisely that is true of stagnant services. Their money prices are indeed rising ever higher, their exchange rate against manufactured goods constantly increasing. But in terms of the number of labor hours it takes to acquire them, over the longer run, their cost is decreasing steadily, if slowly. It is immediately obvious that the claim that we cannot afford them is simply a manifestation of what economists call "money illusion."

But how can that be? The answer is that even the most stagnant of services is undergoing some, albeit modest, productivity growth. The cost disease analysis does not claim otherwise; its workings merely require productivity in the stagnant services to grow much more slowly than that of the economy overall. To illustrate the point, let me return to my favorite example. If the hypothetical Mozart string quartet had been scored for a half-hour performance, then its performance in 1990 required two person-hours of labor, just as it did in 1790, when it might have been written. Thus, there is apparently no scope for the slightest increase in labor productivity. Yet that is only an illusion. Assume that the more recent performance was by a Viennese group of musicians, and that it was played in Frankfurt. A 1990 trip from their Austrian home base to the German auditorium surely would normally have taken no more than several hours. But when Mozart made the trip in 1790 it required six days of extreme discomfort. Certainly, technical progress has reduced the number of hours of labor required to provide a unit of the output in question, thus raising the labor productivity of every itinerant performer, even in live performance (and we know that performers are virtually all itinerant).

There is in fact no service whose productivity is untouched by technical progress to some degree. This rise in labor productivity means, by definition, that it requires ever less labor time to produce a unit of such

a service. And every resulting reduction in labor time spent in producing the service means that those purchasing the service must expend that much less labor time to acquire the wherewithal needed to purchase it. That is the sense in which even education and medical care have really grown steadily cheaper (albeit at a snail's pace, compared to other outputs), even as they appear to become steadily more unaffordable. However, this, at best, can only make a minor contribution toward solving the politico-budgetary problems that stem from the cost disease. More powerful aid must come from a second source.

Productivity growth in the entire economy means we can afford more of everything. In an economy in which productivity is growing in almost every sector and declining in none, it is a tautology that consumers can have more of every good and service: they simply have to transfer some of the gains from the sector that's becoming much more productive into the sector that's becoming only a little more productive. Impossible? Imagine that the real price of health care continues to grow at its current rate for fifty years, and that overall U.S. productivity rises for that period at its historic rate of around 2 percent. In fifty years, the output of every good and service, including education and health care, can increase to more than 3.5 times its 1990 magnitude: an enormous increase in wealth for everyone. But the catch is: the relative composition of the sectors will be drastically different. Medical outlays, instead of constituting 12 percent of the total, as they did in 1990, must rise to more than 35 percent in 2040! And Bill Clinton thought he had a problem.

An analogy can perhaps make this clearer. Suppose we think of the public's consumption of goods and services as the purchase of a bundle containing many components, just as the purchase of a car includes the acquisition of seats, tire, steering wheel, etc. Imagine that the price of steering wheels is increasing at an impressive rate, but that because of the decline in the costs of the other components, cars (equipped with steering wheels) grow less expensive every year. Would one really conclude that steering wheels are growing unaffordable, even when their price grows to 65 percent of the price of the car?

Yes, this happy conclusion is just a bit simplistic. Making the stagnant services affordable for the poor will still be necessary. Managing a service sector of more than 50 percent of the economy will be a massive headache. So, too, will educating the public to understand the difference between the reality and the illusion in the behavior of costs. It will not be easy to convince the layperson that, even though prices of personal services appear to be rising at a phenomenal rate, in fact the costs of those services (in terms of their labor time equivalent) are really declining, because of increases in their labor productivity. But these are the real problems of our future economy. The share of GNP devoted to health care costs isn't one of them. *

(From the New York Times, Friday, October 1, 1993, p. A-22)

Hillary Clinton Raises Tough Question of Life, Death and Medicine

By ADAM CLYMER
Special to the New York Times

WASHINGTON, Sept. 30 — Hillary Rodham Clinton said today that she hoped the nation would engage in a serious discussion about what is appropriate medical care for the elderly and very expensive treatments do nothing for the patient's quality of life.

The First Lady, completing her testimony before the Senate Finance Committee — her fifth Congressional hearing in three days on the President's health care proposals — was prodded by Senator John C. Danforth, Republican of Missouri. He asked her whether the system would have "somebody at some level in a position to say no."

Senator Danforth cited a baby who was kept alive for 11 months without a brain; a separation of Siamese twins of whom one was certain to die and the other had no hope of surviving; and a living baby with low birth weights of whom only 15 percent will be functional, and expensive efforts to prolong life for three or six months at very high cost.

Mrs. Clinton neither responded directly to the examples nor promised anything administratively in the health plan. But she predicted that there would be a more promising climate for serious discussions about such issues. If the plan creates "the kind of health security we are talking about," she said, then people will know they are not being denied treatment for any reason other than it is not appropriate — will not enhance or save the quality of life.

Makes Politicians Nervous

The issue frightens most politicians, who fear that they will be seen as enemies of the elderly, who vote in high proportions. Gov. Richard D. Lamm of Colorado drew widespread antagonism when he said in 1984 that the elderly, if all have, got a duty to die and get out of the way.

Mr. Danforth has raised this issue from time to time since 1987. He has never addressed it as emphatically as Mr. Lamm did, but he was re-elected after, discussing it. He has announced



Senator Daniel Patrick Moynihan, the New York Democrat who is the panel chairman, arriving for yesterday's hearing.

my father and spending literally all day every day talking to doctors and nurses about the very kinds of cases that you are outlining."

There were other tough questions for Mrs. Clinton today, more than she had before the earlier committees. The Senators usually focused directly on financing and bore in with considerable detail. She frequently promised to consider... senatorial arguments for changes and delays.

Senator John Breaux, Democrat of Louisiana, contended that imposing limits on insurance premiums after just one year would give the elderly no chance to start. She told him, "Whether we can get to where we need in two years or over a longer period of time, we are very open to talking with you about that."

Senator Daniel Patrick Moynihan, the New York Democrat who heads the committee, asked how she expected to hold health costs to the rate of inflation when such costs had grown more than twice that fast between 1960 and 1992.

Goal of Zero Growth

She replied, "We should be thinking zero growth as a budget target. This country should be moving toward the medical care system that would be made ciling the economies that some cities, states and health care systems had managed in recent years. And she referred to Mr. Moynihan's own writings on the "cost disease" to argue that health care was being made less productive over time because the payment system rewarded waste and inefficient care.

Senator William V. Roth, Republican of Delaware, asked whether it would not be best to try the Clinton plan experimentally in a few places. She replied that the economies had been achieved in various places under demonstration projects. But "until we get to universal coverage, we are not doing it. We have to control our health care design."

When the hearing ended, the Senators applauded the witness.

that he will not seek re-election next year.

Mrs. Clinton has argued that the budgetary constraints the Administration plan will put on insurance companies and on the elderly. She has repeatedly cited the example of a 92-year-old man given a quadruple heart bypass because the surgeon had referred to a cardiologist who had referred that patient to him, and she suggests that if the system is changed

such surgery will not be performed. She told that same story and offered the same hope today reflecting on her own declining health. She said, "I would agree that for both moral and ethical reasons as well as economic ones, there has to be the kind of very difficult conversation that you are suggesting."

She said she had had a lot of time to think about the issue "on a personal level when I was in the hospital with

Mr. WAXMAN. Thank you very much for your testimony. You raise a lot of important points about the President's plan that provides limits and I can see that you object to those limits. But you certainly can't defend the status quo as the alternative.

Do you have another proposal for us?

Mr. BALCH. Well, Mr. Chairman—

Mr. WAXMAN. Would you want universal coverage without those limits so that there wouldn't be the denial of care?

Mr. BALCH. Mr. Chairman, as a single-issue organization, we don't take a particular stand on any particular alternative, but I would emphasize that universal access would certainly not be incompatible—or universal coverage would certainly not be incompatible with the pro-life position, so long as it does not involve premium caps and rationing of care. I would make a quick point in that response.

We sometimes hear that in order to extend coverage to people who are currently uninsured or underinsured, we will have to impose rationing on everyone, as we heard in Oregon.

But the fact is that even Governor Celeste, who is the person retained by the Democratic National Committee to promote the administration plan, acknowledges that people who are uninsured or underinsured are currently getting treatment, they are just getting it at a poor level and very expensively, for example, being admitted into the emergency rooms rather than seeing a doctor. So it is entirely feasible to perhaps restructure the system in a way that ensures that those people will get adequate care without requiring rationing.

Mr. WAXMAN. Well, I don't think we ought to have rationing either. But we do have rationing now under the status quo where some people don't have insurance coverage at all, don't get access to care because of it, get sicker as a result, are denied what you would call a right to life, and I would say is a right as well for people to respect their dignity, to give them needed medical services, no matter what their situation may be. So I guess on that basis, we should come to the conclusion that we don't want rationing, but we do want rights—rights to health care to be protected for all people. Is that a fair statement?

Mr. BALCH. It is certainly fair to say that the goal of attaining health care for all people, adequate health care for all people, is certainly compatible with the "right to life" position. There are, of course, a series of alternative ways of accomplishing that, and we—

Mr. WAXMAN. Well, do you have an alternative—

Mr. BALCH. I don't think I can say which particular way we would support. We certainly, as long as whatever means is taken to achieve that does not involve imposing rationing, we would have no objection to it.

Mr. WAXMAN. I assume you are here because you asked to testify? Did you want us just to vote no or do you have an alternative to—vote no on the President's plan, which of course would be the status quo, or do you have something affirmative to propose to us?

Mr. BALCH. Well, I think when you say do we have something in particular that is affirmative to propose, we have analyzed the various different plans that are being provided or offered in Con-

gress. And we have indicated, not in this testimony, but I will certainly be glad to supply it with the testimony—

Mr. WAXMAN. We can keep the record open.

Mr. BALCH. The ones that we do not object to on the basis of rationing or other concerns.

Mr. WAXMAN. I appreciate that. Let me ask you, Mr. and Mrs. Cacho, you have—you have enormous expenses that you have to deal with, part of which are paid for by your insurance carrier, but your insurance costs are extremely high. If we had a reform of the insurance system where everybody's insurance coverage was the same, and we had a community rating so everybody in the community paid the same amount for their insurance, which means those who are going to use it a lot are going to be balanced off against those who aren't going to use it at all, do you think that that insurance reform, eliminating preexisting medical conditions or individual underwriting, making sure that the community rating, would that be sufficient or do you think we need to do more, such as subsidize for those who can't otherwise even afford that coverage?

Mrs. CACHO. Well, it is a beautiful start.

Mr. WAXMAN. That would mean a lot.

Mrs. CACHO. Well, that would mean everything.

Mr. WAXMAN. For you, since you are paying such a high rate now, if it were a community-rated amount, you would be able to afford it, because it would certainly be a lot less amount.

Mrs. CACHO. From what I have read, it sounds like we would be able to afford it.

Mr. WAXMAN. But wouldn't you be concerned that there would be a lot of people who still, if they lost their jobs, wouldn't be able to afford the insurance at the community rate?

Mrs. CACHO. Absolutely.

Mr. WAXMAN. And do you think that we need to, as we enact reform, provide universal coverage for everybody, not just the chance to buy it if they can afford it, but if they can't afford it they go without?

Mrs. CACHO. I think everyone deserves to be as healthy as they can be, be as independent as they can be. I don't think money is the criteria here.

Mr. CACHO. I think my wife tried to say it as best she could when she said it is bothersome, this viewpoint of "us" versus "them." And it should really be all of us. And our main issue I think of concern, was that children like Philip, our son, be part of us and that they be included and that they get to be born, or those born with a disability be included in any health care package and be included as "us" and not seen as a separate group.

Mr. WAXMAN. When I talk to people, other countries, other industrial countries, that have national health insurance, and they have their problems with their national health insurance, Canada, or England, or France or Germany, they all have their own problems. And they have the political spectrum to the conservatives, to the left wing, and so forth. But they all, whatever their political views may be, they look at me and they say how can you be from a country where everybody isn't in it together, where the healthy and the sick, the working and the unemployed, the rich and the poor, all have the same stake in the system, that you don't exclude people

because they are not wealthy, they are not working, they are not healthy.

In these other countries, they just cannot understand it. And I tell you, I find a hard time understanding it as well.

Mr. Bergman, did you want to—

Mr. BERGMAN. Yes, thank you, Mr. Chairman. I just wanted to add to the response to the first question.

Certainly universal access, elimination of preexisting condition exclusions, community rating, no surcharging, et cetera, are the foundation for which we have to have reform. But as Mrs. Cacho pointed out in her testimony and Mr. Balch articulated, the next issue becomes what is the scope of the benefit package, what is comprehensive?

And we are very concerned about the new definition of "preexisting condition exclusion" in the President's Health Security Act by saying that outpatient rehabilitation services, physical therapy, speech-language pathology, and occupational therapy services, are only going to be for those who have an illness or an injury.

And upon questioning with the administration, they are clear, that is after birth, illness or injury. So Philip's therapies, which his family has litigated to get their current carrier to pay for, would in fact be lost under the bill as currently on the table.

So we would encourage you to change that to make sure that comprehensive means "comprehensive," regardless of the onset of the disability condition. The same for home health care, the same for extended care. All of those benefits are tied to an illness or injury, therefore being an acute care orientation to health care.

Mr. WAXMAN. OK. Very good point. I didn't appreciate that point, but we will have to look at the President's bill to see what they meant by it, whether people like the Cacho family would be left out when they have a child with cerebral palsy needs that special consideration.

Mr. BERGMAN. If I may respond, what they I think will tell you as they have told us is then, his therapies, Philip's therapies, would be covered under the new non-Medicaid long-term care plan as habilitation services. And as was stated by earlier witnesses and I will restate, under that particular component, which we strongly support, long-term care reform must be a part.

Philip's disability is going to be with him throughout the duration of his life and his family care-giving. But the critical issue is under the proposal, the State has tremendous flexibility, therefore they can pick and choose what they put in there. And even if should habilitative therapies be on that menu in California where they now live, they would still have a copay of 25 percent, no out-of-pocket cap, on top of the premium, on top of the out-of-pocket cap on the basic benefit package.

Again, what that is going to create is a bias for institutionalization, as we have under the current system, as opposed to leveling the playing field and saying how do we support this family to raise this child at home, which is the best place for this child to grow up.

Mr. WAXMAN. Very good point. I appreciate your bringing it to our attention. We will certainly want to look that over very, very carefully.

Philip, you are a good looking young man. We are pleased to have you come all the way from California to be with us, and you certainly have parents who care a great deal about you. Not only you, all the other kids who need to have the care that you have been able to get.

Thank you very much for coming.

Mrs. CACHO. Thank you very much.

Mr. WAXMAN. We are going to recess now and reconvene in this room at 2 o'clock.

[Whereupon, at 12:47 p.m., the subcommittee recessed, to reconvene at 2 p.m., the same day.]

AFTER RECESS

Mr. WAXMAN. The meeting of the subcommittee will come back to order.

Our next panel examines the impact of the President's plan on Indian tribes and tribal organizations. Pamela Iron is the Executive Director of the Health Services Division of the Cherokee Nation. James Hena is the chairman of the All Indian Pueblo Council. James Crouch is the executive director of the California Rural Indian Health Board.

Thank you all for coming here today.

Mr. Synar, who could not be with us today, asked if we would allow him to insert a statement in the record. And without objection, that will be the order. I understand that Pamela Iron is from his district. He wanted me to extend greetings to you.

[The prepared statement of Mr. Synar follows:]

STATEMENT OF HON. MIKE SYNAR

Thank you Mr. Chairman for holding this hearing on health care reform and how it relates to disabled groups, AIDS patients and other special populations such as adolescents. I am especially pleased that Ms. Pamela Iron, the Executive Director of the Health Services Division of the Cherokee Nation is able to share her views on health care reform with the subcommittee. Ms. Iron is involved in the day-to-day activity of providing health care to the Cherokee Nation and has a solid working knowledge of the reform plans before us, making her uniquely qualified to give this subcommittee a new perspective on health care reform.

I am also looking forward to the testimony of those witnesses representing minority populations and believe they will present a vision of health care worthy of special consideration by this subcommittee. Many of the people that we will hear about today are part of the 39 million uninsured in this country which include: children (including foster children), AIDS patients, migrant workers and minorities. When including these populations in health reform efforts, we must also ensure the quality of care they receive, guarantee a high level of preventive care and address their special needs. I look forward to hearing about the impact that the Health Security Plan will have on the groups testifying before the subcommittee today as I believe they represent a broad spectrum of people who have often been overlooked in past health care efforts.

In examining the health care plans that come before this subcommittee, I will keep the interests of these special populations in mind. This country has a duty to provide adequate and available health coverage not only to healthy people, but also to groups like adolescents, minorities and those with disabilities who need good health care coverage to lead solid, productive lives.

Mr. WAXMAN. Your prepared statements will be in the record in full without objection. I would like to ask each of you to limit the oral presentation to no more than 5 minutes.

Ms. Iron, why don't we start with you.

STATEMENTS OF PAMELA IRON, EXECUTIVE DIRECTOR, HEALTH SERVICES DIVISION, CHEROKEE NATION; JAMES S. HENA, CHAIRMAN, ALL INDIAN PUEBLO COUNCIL; AND JAMES ALLEN CROUCH, EXECUTIVE DIRECTOR, CALIFORNIA RURAL INDIAN HEALTH BOARD, INC.

Ms. IRON. Mr. Chairman, as stated, my name is Pamela Iron. I am the Executive Director of the Health Services Division of the Cherokee Nation, one of the first tribes in the Nation to enter into a self-governance compact with the United States Government under the 1988 amendments to the Indian Self-Determination and Education Assistance Act. I am here today to share with you issues involving the impact of President Clinton's Health Security Act on vulnerable populations within the Cherokee Nation and among all tribes in this country.

Indian populations as a whole within the United States are vulnerable, largely for three reasons. First, they are poorer and less educated, on average, than comparably situated non-Indians. This is even more of a hardship for Indian patients, particularly elderly Indians who speak primarily Indian dialects and use little or no English.

Second, Indians are served primarily within rural Indian health systems where both primary and specialized health services are difficult to obtain because they are located long distances from rural Indians.

Finally, funding for health services is wholly inadequate, leading to fragmentation of services and overcrowded health facilities. In the Cherokee Nation alone, we have four systems. Indian people go to the private physicians. There is an urban Indian health care delivery system. The Indian Health Service has direct delivery. And the tribes deliver health services, which causes a lot of fragmentation.

While a package of health care benefits is guaranteed under the President's plan, it may be meaningless to many rural Indians if they are unable to gain access to services because of lack of transportation. It is not enough to provide health services; they must be accessible. And although transportation is not a glamorous delivery of health care, it is very necessary we did a study in our clinic at the Redbird Smith Health Center, and the prenatal rate of no-shows increased 60 percent in that actual clinic because we provided transportation.

Therefore, it is essential under the President's plan that mechanisms for establishing and funding transportation services for rural areas be developed. The President's plan lacks a strong health promotion and disease-prevention component. However, this is essential for decreasing the vulnerability of Indian populations. We believe that these programs form the cornerstone of an effective health system.

Indians have seven times greater risk of death from tuberculosis than the population at large, six times greater risk of death from alcoholism, and 2.5 times greater risk of death from diabetes and accidents, and tuberculosis is on the rise.

However, these conditions or complications from these conditions can be prevented. However, the President's plan only permits but does not require that health education programs be conducted by

each health plan. In addition, it does not specify cost-sharing mechanisms for these programs as was done with most other services in the guaranteed benefits package.

We ask that Congress mandate that health plans offer health promotion and disease prevention programs as part of the guaranteed benefits package and that allocations and appropriations for Indian service programs include the cost of these preventive services.

Within an already vulnerable Indian population, certain groups face additional hardships. Elderly Indians and Indians with disabilities are particularly vulnerable. President Clinton's health care plan offers improved health care services largely due to provisions with greatly enhance home and community-based services, particularly for the severely disabled.

The administration is to be commended for this. However, it is unclear in reviewing the President's plan where Indian programs fit into this system. Currently, States fund many long-term care services for low-income Indians through the Medicaid program.

It is unclear if this would continue in a reformed system. If it does not, mechanisms need to be clearly identified within the President's plan for funding a portion of the various long-term care programs for Indians which would otherwise be paid as part of the State matching funds.

It is essential that the sufficient funding to fully support services for Indians be available consistent with the government's trust obligations to Indian people. We are concerned that the President's plan continues a long history of underfunding of Indian programs. The standing of the Indian tribes is sovereign governments, engaged in government-to-government relationships with the United States, places a heavy responsibility on both the tribes and the Federal Government to ensure that health services to Indians are wholly sufficient to meet the needs and enhance the health status of all persons served within the Indian health system.

And I would like to conclude by saying that in discussions held by tribal leaders throughout the United States, many feel that the Health Security Act is another attempt at terminating tribal rights. And in addition, it was felt that tribal groups were not consulted totally in the writing of the section on Indian Health Service.

[The prepared statement of Ms. Iron follows:]

STATEMENT OF PAMELA IRON, EXECUTIVE DIRECTOR, HEALTH SERVICES DIVISION,
CHEROKEE NATION

Mr. Chairman. My name is Pamela Iron. I am the Executive Director of the Health Services Division of the Cherokee Nation, the second largest Indian tribe in the United States. The Cherokee Nation was one of the first tribes in the Nation to enter into a Self-Governance compact with the United States Government under 1988 amendments to the Indian Self-Determination and Education Assistance Act. We are committed to the provision of high quality and comprehensive health services for our people. I am here today to share with you issues involving the impact of President Clinton's Health Security Act on vulnerable populations within the Cherokee Nation.

Indian populations as a whole within the United States are vulnerable, largely for three reasons. First, they are poorer and less educated, on average, than comparably-situated White populations. This is even more of a hardship for Indian patients, particularly elderly Indians, who speak primarily Indian dialects and use little or no English. Second, Indians are served primarily within rural Indian health systems where both primary and specialized health services are difficult to obtain

because they are located long distances from rural Indians. Finally, funding for health services is wholly inadequate, leading to fragmentation of services and overcrowded health facilities.

While a package of health care benefits is guaranteed under the President's plan, it may be meaningless to many rural Indians if they are unable to gain access to services because of lack of transportation. It is not enough to provide health services; they must be accessible. Therefore, it is essential under the President's plan that mechanisms for establishing and funding transportation services for rural areas be developed.

The President's plan lacks a strong health promotion and disease-prevention component. However, this is essential for decreasing the vulnerability of Indian populations. We believe these programs form the cornerstone of any effective health system. Indians have seven times greater risk of death from tuberculosis than the population at large, six times greater risk of death from alcoholism and two and one-half times greater risk of death from diabetes and accidents. These conditions or complications from these conditions can be prevented. However, the President's plan only permits, but does not require that health education programs be conducted by each health plan. In addition, it does not specify cost-sharing mechanisms for these programs as was done with most other services in the guaranteed benefits package. We ask that Congress mandate that health plans offer health promotion and disease prevention programs as part of the guaranteed benefits package and that allocations and appropriations for Indian health programs include the costs of these preventive services.

Within an already vulnerable Indian population, certain groups face additional hardships. Elderly Indians and Indians with disabilities are particularly vulnerable. President Clinton's health care plan offers improved long-term care services, largely due to provisions which greatly enhance home and community-based services, particularly for the severely disabled. The administration is to be commended for this. However, it is unclear in reviewing the President's plan where Indian programs fit into this system. Currently, States fund many long-term care services for low-income Indians through the Medicaid program. It is unclear if this would continue in a reformed system. If it does not, mechanisms need to be clearly identified within the President's plan for funding the portions of the various long-term care programs for Indians which would otherwise be paid as part of State matching funds. In addition, expansion of home and community-based services for the less seriously disabled should be considered as part of a long-term strategy for improving care for the elderly and disabled.

It is essential that sufficient funding to fully support services for Indians be available, consistent with the Government's trust obligations to Indian peoples. However, funding for Indian health programs within the American Health Security Act appears to be inadequate to support the costs of delivering the guaranteed benefit package to Indians. We are concerned that the President's plan continues a long history of underfunding of Indian programs. For example, the expressed commitment by Congress in the Indian Health Care Improvement Act to promoting the highest level of health care for Indians and acknowledging the responsibility of the Federal Government to ensure that these services are available has failed to produce adequate funding to carry out the clearly-stated purposes of the Statute.

The standing of Indian tribes as sovereign governments, engaged in government-to-government relationships with the United States, places a heavy responsibility on both the tribes and the Federal Government to ensure that health services to Indians are wholly sufficient to meet the needs and enhance the health status of all persons served within the Indian health system. We implore Congress to ensure that any health plan which is enacted ensures that funding for Indian health care is adequate to truly meet the needs of all Native Americans.

Mr. WAXMAN. Thank you very much.

Mr. Hena?

STATEMENT OF JAMES S. HENA

Mr. HENA. Thank you, Mr. Chairman. Good afternoon. My name is James Hena. I am chairman of the All Indian Pueblo Council in New Mexico.

I want to apologize. I wasn't aware there was going to be an official hearing. I thought it was going to be a staff orientation. Consequently I didn't prepare my testimony in the usual manner. But I will just reiterate some of the information I am presenting.

The American Indian population is about 133 million, according to the 1990 census. The growth rate nationally is about 2.35 percent. The median age for Indians is 25 compared to 33 for the rest of the country. Median household income for American Indians is about \$20,000 per year, compared to \$32,000 for others, which is usually the case. We Indians are usually about one-third behind everybody else, and we are always trying to catch up, whether that is funding for health, comfort, and other kinds of things.

Leading causes of death for American Indians are diseases of the heart and accidents. There is a very high rate of diabetes among Indians, especially among Southwest U.S. tribes, and the mortality rate due to diabetes, that is supposed to be 2.54 percent greater among Indians than other Americans.

I myself am a diabetic. I contracted the disease some 3 years ago. I weighed almost 200 pounds at that point in my life and after I learned I was a diabetic, my weight came down to about 150. Since then, I have regained about 15 pounds of that.

Suicide among Indians is 54 percent greater compared to the general U.S. population. There are no programs specifically addressing the needs of the Indian elderly population, which is about 250,000. For instance, in the bill it mentions generally long-term care, but it doesn't go into any specifics.

I wanted to bring your attention to a policy within the Indian Health Service presently called YPLL. These letters stand for Years of Productive Life Lost. An example would be if a child 5 years old came into an Indian Health Service medical facility for, say, brain surgery, and at the same time an elderly Indian came in for the same purposes, the Indian Health Service, because of lack of sufficient funds, would forego operating on the elderly person because he or she has had 80 years of life, let's say, compared to a young child that is 5 years old. They determine that young child has maybe 60, 70, 80 years more to live, so the priority goes to the younger child. Consequently, the elderly person is left to die.

In fiscal year 1991, there were over 93,000 admissions to Indian Health Service medical facilities nationwide. Outpatient visits in fiscal year 1991 were over 5.2 million. In fiscal year 1992, there was a deficiency of \$594 million for construction of sanitation, water/sewer infrastructure, on Indian reservations in the United States.

Indians want to maintain the United States Indian Health Service as it exists now. There is a tremendous shortfall annually to meet the health needs of the 1.33 million Indians today and opening IHS facilities to non-Indians would only exacerbate the lack of adequate services in Indian country.

A recent Indian Health Service estimate indicated that there is somewhere in the neighborhood of \$3.5 billion needed for water, sewer and environmental purposes, as well as for renovation of medical facilities or expansion of such facilities. They also indicated that there is a need for about \$2.3 billion for provisions of the President's health bill.

One of the things that I would like to speak to is the need in this bill for language that would provide for direct funding to Indian tribal governments, rather than funding to the States. I think if you did any research on this, you will find that there are numerous

States that have disclaimer clauses in their State constitutions as a result of the Congress making that requirement because of the history of their treatment towards Native Americans while they were territories. And normally because of that history, States and Indian tribes have an adversarial relationship. And consequently when Congress passes laws that provide for financing to State governments, we don't get very much done at the reservation level.

Thank you for your attention, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Hena.

Mr. Crouch?

STATEMENT OF JAMES ALLEN CROUCH

Mr. CROUCH. Thank you, Mr. Waxman. It is an honor to be here today.

I know you are very familiar with the Indian Health Service and the nature of that program and the relationship with the core benefit package as proposed by the health reform plan to the existing IHS services, the supplemental services and other responsibilities to the Indian Health Service.

I wanted to begin by saying that we believe in California that the general contour of Mr. Clinton's health plan is a vast improvement over the existing IHS system. The existing system is too highly centralized. It is chronically underfunded. In California, we are providing broader than a core benefit package in some ways on a funding per capitated amount of less than \$1,200 per individual. The Clinton plan proposes the comparative number for California in the neighborhood of at least \$1,900 per individual. Our responsibilities for that \$1,200 amount would include environmental health and other things are not part of the core benefit package.

The other problem with the Indian Health Service currently resides under funding is the chronic inability to judge exactly where it is at. There is no defined benefit package. There is no measurement that we can use to really know the progress that we are making or not making. So we would encourage you to consider a definition for the benefit package within the IHS.

There are two things that are not in my written testimony that I wanted to speak about. One is the issue of transition. The Clinton plan assumes that the States will transition into health reform over a 3-year period starting in fiscal year 1995.

California, which is highly likely, as one of the earliest States to transition into the health reform system, if IHS funding to provide services comparable to the defined benefit package available through the alliance structure had not been appropriated, then we would be unable to compete with our neighbors. The Indian clients we now serve would realistically and rationally seek services elsewhere, even though they would lose the concepts of community control, cultural competence, and other aspects of the IHS tribally operated system.

So we urge you to consider transition and the way that the IHS would fit into the transition of State alliance-based plans or any other national health reform.

Second, we are concerned, and I know I have spoken with you before on this, on continued access to AFDC and categorically defined Medicaid clients. The current health plan really does not pro-

vide for access by the Indian programs to those clients. It, in fact, requires that we continue to consider the IHS as a residual service. And if the States should place those clients into other plans, we would not be able to receive funding for them.

Fourth, we would like to support comprehensive reform, manpower reform, paperwork reform, continued improvement in public health programming. In California, the Indian program's inoculation rate runs over 87 percent of children do have their children's inoculations.

We support universal access. We support any health reform that would foster system development.

In closing, I would like to comment that no other plan now on the table addresses the Indian population specifically, not the Chafee plan or any other. I would urge you to include some sort of Indian component to any piece of legislation that is finally passed out of this committee, even if it is something as simple as a unified billing form. The Indian program improvements could be attached to that.

I would suggest those improvements include the requirement for the provision of a defined benefit package, actuarial based and regionally defined funding to provide the required services, decentralized program responsibilities as practiced now in California under the Indian Self-Determination Act and others, maintenance of a distinct IHS system and maintenance of the existing body of Indian law and of course affirmation of tribal sovereignty, the bedrock of all relations between tribes and the United States Government.

If you could see fit to add those to anything that this committee supports, I think that you would go a long way towards improving health care to California Indians and Indians from out of State who receive care in California, and the Indian population in general.

Thank you.

[Testimony resumes on p. 131.]

[The prepared statement of Mr. Crouch follows:]

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REMARKS BY

JAMES ALLEN CROUCH, M.P.H.

EXECUTIVE DIRECTOR

HOUSE SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT

JANUARY 24, 1994

California Rural Indian Health Board (CRIHB) is a Tribal Organization contracting under the provisions of the Indian Self Determination Act to provide comprehensive health care services to twenty-seven tribes in a fourteen county services area of California. Initially founded in 1969, CRIHB also serves as an association representing an additional ten tribes which serve an additional five counties within the state. Collectively, CRIHB related programs provided health care services to 21,239 active Indian Health Service (IHS) Users in FY 92. (The most recent year for which verified national data exists.)

California is the only Area within the IHS system in which all IHS funded services are provided through contracts with Tribes and Tribal Organizations. This is a point of grate pride given our belief in the "Government-to-Government" nature of Federal/Tribal relations and the value we place on self determination for all peoples. California is also unique in that it is the only IHS Area in which the IHS has no hospital facilities. This accident of history, along with chronic underfunding, long ago lead us to the conclusion that operating as part of a integrated rural health care delivery system was the key to our long-term success and the most efficient use of federal resources. Inevitably our analysis of the Clinton Health Plan is shaped by these factors which define our existing operating environment. For a number of reasons which I will outline below CRIHB enthusiastically supports the need for meaningful reform both within and beyond the IHS funded health care system.

The general contour of the Clinton Health Plan for Tribal populations is a vast improvement over the existing IHS system. At a National Indian Summit on Health Care Reform held in Washington, D.C., last March, a national Indian consensus on health care reform was established. The nonnegotiable items from that consensus included reaffirmation of the sovereignty of Indian Tribes, maintenance of the body of law that governs Indian Affairs, and maintenance of a distinct federal Indian Health Service. Beyond conserving these fundamental elements there was, also, great support for the need to change the current underfunded, federally dominated, geographically fragmented, obstinately bureaucratic system. The Clinton Plan as expressed in

H.R. 3600/S. 1757 affirms the sovereignty of Tribes, upholds the existing body of Indian Law, and maintains a distinct federal Indian Health Service. Additionally, the plan will transform the IHS system in several ways that will markedly improve the ability of the IHS to meet its mission of improving the health status of the Indian people.

COMPREHENSIVE BENEFIT PACKAGE

The Indian Health Service does not provide a defined set of health care services to its eligible population. The result is an absence of accountability that comfortably masks the sometimes glaring shortfall between need and availability. Hiding behind this mask are local IHS care providers who are additionally protected by "best effort contracts" and federal financial management requirements. At the next level, where services are abstractly viewed as funds, IHS officials point the budget constraints of the Department of Health and Human Services as limiting their ability to do what needs to be done. At the Departmental level, they point to the Office of Management and Budget which in turn points to Congress. And in Congress one part of Congress speaks to the other and says "The IHS is a discretionary domestic program - It is, therefore, merely an administrative aberration that one Indian receives a service while another goes without." This circle of denial continues out to the general public who, in the absence of a defined measuring stick, comfortably continues under the assumption that Indian health care is well funded.

ACCOUNTABLE DECENTRALIZED DELIVERY SYSTEM

The Clinton Health Plan establishes the responsibility of the IHS to provide the defined comprehensive benefit package to Indians who enroll in the IHS system as their provider of choice. Significantly, it also establishes that all IHS funded providers (IHS directly operated Service Units, Tribal Contractors, Urban Indian Programs, and Tribes operating under Government Compacts) shall provide the comprehensive benefit package. This authorization of subsystem equality and responsibility is further reinforced by the establishment of comprehensive benefit funds (risk pools) at the local delivery level. This is a major step away from the current highly centralized system and a major reform.

MIXED FUNDING FOR IHS SERVICES

The Clinton Health Plan establishes two new funding streams for the reformed IHS system: 1) Employer insurance premiums, and 2) Premium subsidy amounts for unemployed and partially employed Indians. In a way, mixed funding is not new to the IHS whose annual budget historically includes appropriated and non-appropriated budgeted amounts. What is new for employer-related funding is the capitated and prospective nature of that funding. These changes will add stability to the system. Similarly although the IHS system has historically collected some state or county funding for providing services to the medically indigent, the availability of these funds varies greatly and is generally in decline. The Clinton Health Plan establishes uniform national coverage for the medically indigent and elevates the collection of those funds by the IHS to a form of entitlement. This change also adds stability to the system. It would be helpful, however, if there was also a legislative requirement that the discretionary funding stream fully fund any shortfall in funding necessary to provide

the guaranteed comprehensive benefit package to eligible IHS enrollees. This provision would prevent erosion in IHS provided services such as environmental health services, public health nursing and community focused health education which are not part of the Clinton Health Plan comprehensive benefit package. The importance of these services to maintain and improve the health status of Indian people is clear.

NATIONAL HEALTH REFORM

Comprehensive national health reform is beneficial to IHS funded health care providers in many ways. Tribal Contractors, like CRIHB, face the same obstacles in recruiting trained health professionals as other systems that provide services to rural and underserved populations. Shifting the emphasis in national Medical education away from the training of specialists to the training of primary health care providers would improve our ability to recruit an adequate supply of frontline providers. Likewise, streamlining the billing process by establishing a uniform billing form would reduce the administrative cost of operating as an integrated health care provider. More importantly, it would help bring an end to the current practice of aggressive cost avoidance which often delays or prevents necessary care.

IHS REFORM REGARDLESS OF NATIONAL OUTCOMES

Because the IHS already exists as a National Health Alliance for the Indian population reform of the IHS within the context of the Clinton plan, it is easy to envision and to carry out. However, national resistance to the Alliance system or to employment based universal access should not preclude significant reform of the IHS during this session of Congress. The key elements of IHS reform should be built into any final program of Congressional health reform. Those elements are as follows: 1) The requirement for the provision of a defined benefit package to all IHS enrollees; 2) Actuarial-based full funding of the required services; 3) Decentralized program responsibility; 4) Maintenance of the distinct IHS system; 5) Maintenance of the existing body of Indian Law; and 6) The affirmation of the sovereign nature of Indian Tribes.

THE HEALTH SECURITY ACT

H.R. 3600 - S. 1757

INDIAN SPECIFIC SECTION

SECTION 8301 DEFINITIONS: This section establishes the parity of Tribal Organizations with IHS operated facilities, Self Governance Compacts and Urban Indians as "Health Programs". This definition is critical to the decentralization of the IHS system into a new I/T/U system.

SECTION 8302 ELIGIBILITY: This section leaves intact the existing IHS eligibility. It specifically includes Section 809 of the IHCIA on California Indians.

SECTION 8302 (b) Election operationalizes the concept of individual choice. It establishes enrollment at the Service Unit, Tribal Contractor and Urban Program level. Later in the Act, there are provisions for Indian Program/Alliance contractual relations. THERE NEEDS TO BE SPECIFIC LANGUAGE ON INTER-I/T/U BILLING. There is currently an IHS operating policy that stipulates that any IHS eligible may access direct care services at any IHS funded program without any subsequent exchange of funds. This old policy is directly in conflict with the new environment based on program level enrollment process and a capitated funding process.

SECTION 8302 (d) Payment by Individuals who do not Enroll-- This section clearly establishes a financial liability for individual Indians who choose to receive their care from non-I/T/U providers to pay all copayments and fees that may be required by their health plan of choice. This is a clear financial incentive for employed IHS eligibles to elect to receive services from the I/T/U system. Subsidies for Indians with low incomes who select out of the I/T/U system would be available for those Indians on the same basis as other citizens. In short the prime motivators for most current users of the I/T/U system to stay with that system would be their perceptions about quality, cultural competence and local control. This mix of incentives is good in that it encourages broad utilization of the I/T/U system without creating lock-in. As is the case for the Indian who elects to use the I/T/U system, the non electing Indians may expect to receive core benefits services from any IHS funded provider without charge. THEREFORE, THERE NEEDS TO BE SPECIFIC LANGUAGE ON THE RIGHT OF I/T/U PROVIDERS TO EITHER REFUSE SUCH SERVICES OR TO RECEIVE PAYMENT FROM THAT INDIVIDUAL OR THEIR ALLIANCE THROUGH A PRIOR APPROVAL PROCESS. This provision would cover random utilization where contracts would be impractical.

SECTION 8303 SUPPLEMENTAL INDIAN HEALTH CARE BENEFITS-- This section affirms that regardless of where an Indian elects to receive their comprehensive benefit care all IHS eligibles remain eligible for supplemental (non comprehensive benefit) services provided through the IHS under other authorizing legislation. And that these services should continue to be provided without charge.

This section also authorizes Congress to appropriate \$180 million in FY 95 for these purposes. This authorizing language would be additive to that which exists in the Indian Health Care Improvement Act and the Omnibus Alcohol Act. It should be noted that those authorizations have never been fully funded by the Appropriations Committees.

SECTION 8304 HEALTH PLAN AND ALLIANCE REQUIREMENTS-- This section mandates that the Secretary of Health and Human Services ensure that the comprehensive benefit package is provided by all programs (IHS direct, Tribal and Urban) of the IHS by January 1, 1999. This is a reasonable timetable given the vast amount of program development that needs to occur.

HOWEVER, THERE NEEDS TO BE LANGUAGE WHICH REQUIRES THE IHS TO PHASE IN THE AVAILABILITY OF THE COMPREHENSIVE BENEFIT PACKAGE AS IT BECOMES AVAILABLE IN EACH STATE. I/T/U system providers must be able to provide the CBP on the same day that the Alliance based system in their area goes into business. Anything less would render the I/T/U providers noncompetitive and should be considered programing for failure. This state by state phase-in is counter to traditional IHS funding approaches.

SECTION 8304 (b) Applicable Requirement of Health Plans. -- This section gives the Secretary, DHHS, the authority to determine "which other requirements relating to health plans apply to the I/T/U provider." To some extent this will bind the I/T/U providers to achieving "look-a-like" status with health plans as defined in the act. This is potentially helpful to the extent that the Indian people should not be segregated into a second-class system. However, the traditional command and control IHS management style may lead to an erosion of decentralization as envisioned elsewhere in the HSA and the ISDA in the effort to assure quality and accountability.

SECTION 8304 (c) Certification sets a deadline of January 1, 1999, for IHS certification as a Health Plan and call for certification of "all such Indian Health Programs" to the extent possible. The limiting phrase on the certification of I/T/U providers seems well placed given existing IHS underfunding and the small size of many I/T/U providers.

SECTION 8304 (d) Health Alliance Requirements-- This section acknowledges that the IHS logically carries out some functions that are assigned to the Alliance system such as actuarial based costing and quality assurance functions. Therefore, the Secretary, DHHS, is directed to identify those Alliance requirements that are applicable to the IHS. These sections are best viewed as role identification activities to clarify the functions of the IHS within the new environment. The product of these activities will need to be reviewed by I/T/U providers for appropriateness.

SECTION 8305 EXEMPTION OF TRIBAL GOVERNMENTS AND TRIBAL ORGANIZATIONS FROM EMPLOYER PAYMENTS-- This section is a partial recognition of the government-to-government nature of Federal/Tribal relations. It builds from the ISDA language which prevents IHS from billing Tribal Self-Insurance Plans for health services provided to Tribal employees. This provision also covers employees of PL 93-638 Contractors an extension which saves the administrative costs of awarding funds under Indian Self-Determination Act Contracts and then requiring that those funds be returned to the Treasury to cover the cost of the comprehensive benefit package.

As written this exclusion would cover all employees regardless of IHS eligibility or individual choice of health care provider.

SECTION 8306 PROVISION OF HEALTH SERVICES TO NON-ENROLLEES AND NON-INDIANS. This sections establishes the opportunity for I/T/U providers to enter into contracts with local Alliance governed health plans. This opportunity is governed by the existing requirement that such services will not diminish the availability of services to the Indian community. Reimbursement for these services would be governed by essential provider provisions which will be either under a fee schedule established by the relevant Regional Alliance or by the Secretary of Health and Human Services. Section 1431 (c) may also apply to inter-program reimbursements between I/T/U providers. Clarification on this point would solve the problem of "crossover utilization" by IHS beneficiaries. THERE IS A NEED TO CONTINUE THE REQUIREMENT FOR FULL REASONABLE COST REIMBURSEMENT FOR ANY SERVICES PROVIDED TO NON IHS ELIGIBLES. ANYTHING LESS POTENTIALLY RESULTS IN A MIS ALLOCATION OF CONGRESSIONALLY APPROPRIATED INDIAN FUNDS.

SECTION 8306 (b) Family Treatment allows for the enrollment of non-Indian family members into the I/T/U system. In the case of Family enrollment the Indian family members would not be subject to any premium or copayment requirements although non-Indian members would be charged those fees and premiums. These premiums would be subject to the same standards set by the local Regional Alliance for the so called "low cost plan".

SECTION 8307 PAYMENT BY OTHER PAYERS. This section leaves in place the provisions of the Indian Health Care Improvement Act concerning the right of I/T/U providers to bill and receive payments from both private and Governmental Insurance programs such as Blue Cross, Medicare, Medicaid and Medi-Cal. This section also establishes in statue of the Indian Health Service as the payer of last resort.

Some Tribes and the National Congress of American Indians advocate for the IHS to be the primary payer within a framework of Indian entitlement. That approach would clearly prevent third-party collections and force Congress to fund all Indian health care through tax revenues. IT WOULD BE HELPFUL IF THIS SECTION INCLUDED LANGUAGE THAT PREVENTED STATE MEDICAID PLANS FROM ESTABLISHING MANAGED CARE PLANS THAT PREVENTED INDIAN INDIVIDUALS AND INDIAN FAMILIES FROM SELECTING AN I/T/U PROVIDER AS THEIR MANAGED CARE PROVIDER OF CHOICE.

SECTION 8308 CONTRACTING AUTHORITY. This section amends the Indian Health Care Improvement Act by providing for the purchase of "direct health services". This authority would allow the IHS to contract for the provision of the comprehensive benefit package.

SECTION 8309 CONSULTATION. This section requires that the Secretary consult with representatives of Tribes, tribal organizations and urban Indian organizations annually concerning health care reform. This section clearly extends the right to participate in consultation to tribal organizations and urban Indian organizations. Although in practice such consultations generally occur on occasion, tribes participating in multi-tribal organizations have been disadvantaged through the exclusion of their designated health delivery system from significant discussions.

SECTION 8310 INFRASTRUCTURE. This section addresses the documented need for facility improvement for I/T/U providers if they are to be competitive within the new health reform environment. Currently IHS facility construction is based on a priority system that has targeted facility construction to large tribes and systematically ignored the need for small ambulatory facilities. Persistent underfunding of this process has led to deterioration of physical plans even for larger programs. This section authorizes funding for construction and renovation of hospitals, health centers, health stations and other facilities for the delivery of items and services guaranteed in the comprehensive benefit package.

SECTION 8310 (b) establishes a revolving loan program to improve and expand health care facilities to enable I/T/U's to provide the comprehensive benefit package. It is not clear whether this revolving loan program would augment or supplant the existing IHS construction program. An unintended outcome of the existing IHS facility program is that it penalizes those Tribes and Tribal health programs who operate out of leased facilities, or who borrow funds to meet their own construction needs.

These programs, in effect, are forced to reduce program activity to meet facility costs while those lucky few who make the IHS facility construction priority list receive new facilities as an augmentation to existing program activity.

FOR THIS REASON I/T/U PROVIDERS IN EXISTING FEDERAL FACILITIES SHOULD BE REQUIRED TO AMORTIZE THEIR FACILITY CONSTRUCTION COSTS AS A MEANS OF PARTIALLY FUNDING FUTURE CONSTRUCTION REPLACEMENT COSTS.

SECTION 8311 FINANCING. This section authorizes each program of the IHS (THIS SHOULD MORE APPROPRIATELY READ: each I/T/U provider) to establish a comprehensive benefit package fund. In the new capitated system this fund would serve as the risk pool to cover all costs associated with the provision of the guaranteed benefit package. Within this fund each enrolled IHS beneficiary, or non-Indian family member, would have an account which would be funded from various sources. The identified capitated amount for each individual would be dependent on geography, age, sex and health status.

Into this fund would be deposited employer premium payments for employed Indians, family premium payments for non-Indian members of Indian families and amounts appropriated for the provision of the guaranteed benefit package to IHS eligible individuals and any other fund amounts received with respect to health services for the comprehensive benefit package.

Administration of the fund rests with each health program (I/T/U provider) of the IHS with the limitation that all amounts within the fund shall be expended for the provision of the defined comprehensive benefit package. Amounts deposited to the fund are available for that purpose until expended. [NOTE UNDER SECTION 8311(C)(3) REFERENCE TO SERVICE UNITS SHOULD BE CHANGED TO: PROGRAM OF THE IHS OR I/T/U PROVIDER.]

SECTION 8312 RULE OF CONSTRUCTION. This section directly states that no part of the Health Security Act shall be construed to rescind or otherwise modify the findings, obligations, or purposes contained in the Indian Health Care Improvement Act, or the Indian Self Determination Act.

SECTION 8313 AUTHORIZATIONS OF APPROPRIATIONS. This section authorizes specific funds to the IHS for FY 95 through FY 2000 which are additional to the regular IHS appropriation and amounts authorized elsewhere within the Health Security Act. These amounts are set at \$40 million for the first year and balloon to \$180 million in FY 96. These funds would be used to fund the employee portion of premiums and individual copayments necessary to provide coverage to employed Indians who are exempt from individual liability for those cost and employer portions of the premium for employees of Tribes and Tribal Organizations for

EXECUTIVE DIRECTORS REPORT

JAMES ALLEN CROUCH M.P.H.

JANUARY 22, 1994

IHS CONTRACT 0003

As we prepare to enter year three of this three year contract, it is appropriate to take stock of several key issues which speak to the long-term health of this organization. It is encouraging to note that the funding of Contract Support Costs (indirect costs) associated with this contract are for the first time being fully funded by the IHS. This change will bring an additional \$1,448,000 to the contract, effective April 1, 1994. The distribution of this increase amount is governed by the Indirect Cost Proposal submitted to the IHS, and the DHHS Office of Cost Allocation last summer and IHS accounting data. The Central Office portion of this increase is \$345,404. The relative size of this amount to the amounts to be allocated to the five contracting programs is reflective of earlier board decisions to fund local contract support costs first in previous years. *Spent*

A planning process to budget this increase amount has already begun. This process included discussion of CRIHB program needs, a listing of suggested program improvements, a subsequent prioritization of those suggestions by Central Office Management staff, General Staff and contracting program Executive Directors. All discussions were structured within the context of the CRIHB Strategic Plan as Amended 10/16/93. This information will be reviewed by a joint meeting of the Executive Committee and Finance Committee, scheduled for February 26, 1994. Positions previously authorized by the board and funding of predictable cost increases leave approximately \$220,000 to be programmed.

Formalized indirect cost accounting has its downsides too. Funding for indirect cost pool costs for non-IHS contracts can not be taken from the IHS funded amounts. These contracts such as the State Indian Health Program contract and the federal Health Careers contract, in effect, create a shortfall which must be funded through third party collections. Last year our fee for service account collected approximately \$17,000 in payments. It should also be noted that currently DHHS Region IX has refused to set a formal rate for CRIHB, a problem which is being addressed by the Office to Tribal Activities in Rockville.

CONSULTATION

The Area Office has formed a special work group to develop a consultation plan for the Area. Members of this task group are Dale Risling, Eileen Bowie-Meyer, Ralph DeGarmo, Thomas Brown, Anita Silva, Sonny Hendricks, Tony Largo, and David Dominguez. It

individuals who choose to receive comprehensive benefit package service through the I/T/U system. This language leaves a major portion of the IHS program as a discretionally funded domestic program. Given the historic underfunding of the IHS and the constraints of the recent "Five Year Congressional Agreement" it is possible that Congress would fail to fully fund these costs. This failure would at best lead to an erosion of the non-core benefit IHS services. At its worst it could lead to the collapse of the I/T/U system. In effect under funding would leave the I/T/U providers in the impossible position of being mandated to provide a defined set of services for which they were not sufficiently funded to provide. It is also likely that the amounts authorized in this section are far too low to meet the projected need even when added to the total existing IHS funding base.

Section 8314 PAYMENT OF PREMIUM DISCOUNT EQUIVALENT AMOUNTS FOR UNEMPLOYED INDIANS This section authorizes the Secretary of Health and Human Services to quantify the amount of funds necessary to fund the premium costs subsidy amounts associated with the provision of comprehensive benefit services to unemployed and under employed Indians who are enrolled users of the I/T/U system. This amount is the equivalent amount that would have otherwise have been paid by the Treasury to state based Health Care Alliances had they provided those same services. This section establishes an entitlement type funding stream for a part of the IHS program in that the Secretary of the Treasury directly and automatically pays the Secretary of Health and Human Services the annually certified amounts. GIVEN THE GENERAL UNDER FUNDING OF THE IHS IT WOULD BE MORE APPROPRIATE IF THERE WERE AUTHORITY FOR ADVANCE PAYMENT OF THESE FUNDS AND AT LEAST QUARTERLY DISBURSEMENT OF THE CERTIFIED AMOUNTS.

Mr. WAXMAN. Thank you very much, Mr. Crouch.

On a previous panel we had a witness from the National Right to Life Committee who testified against the President's bill on the grounds that it would lead to rationing of health care. As you three well know, one of the classic examples of rationing in our current system is the IHS, which is chronically underfunded.

My question is this. Do you believe that the Clinton plan would result in more rationing for Indian people than they face now, or will it reduce rationing of care to Indians?

Ms. IRON. We will start off answering, Mr. Waxman. We have looked at this question very carefully. While in some areas it looks like that there would be increased services, there are concerns about the way it would be funded. For instance, on the peridostheny charts, on the preventive health care, there are mammography screenings that actually, in the Cherokee Nation, there is a delayed waiting or rationing of mammography, where in fact it does show that the peridostheny charts would guarantee mammography, maybe really not at the rate we would say is every 2 years, and it probably should be one, but yet the comparison is better. And we would endorse the President's plan in the clinical preventive area.

On the other hand, the Cherokee Nation, I believe the cost per patient is around \$900. In our health care system, nationally it is about, I believe, \$1,500 for Indian Health Service patients. So you can see there is disparity among the different States or different regions.

Mr. HENA. I think that while the plan sounds like it would benefit America's Indians, I am not too sure whether any in-depth analysis has been done in order to compare the cost on a per capita basis in terms of what it would cost Indians in the rural areas as far as the national population is concerned. People tell me there is a discrepancy of approximately 2,000 based on per capita comparisons.

And so while the plan looks good, it may not be something workable, especially because Congress has always been reluctant to finance the costs for Indian health programs in this case adequately. Right now we are experiencing as the result of a Presidential Executive Order to reduce staffing in the Indian Health Service. That alone is raising some concerns on the part of various Senators and Congressmen who have Indian tribes within their districts.

And it seems to me like it would be appropriate for the U.S. Government to waive the requirement that I think is coming out of the reinvention of government initiative, so that there is not another reduction of funding for Indian Health Services in this case.

Mr. CROUCH. I guess I would like to say I think the Clinton plan moves us in the right direction significantly. Currently the Indian Health Service is a discretionary domestic program and it is clear to anyone observing the facts and the numbers that it is grossly underfunded. The Clinton plan would move that into a mixed funding situation that would bring in appropriations, the current \$2 billion that we have on board; it will bring in employer contributions, which I don't think it will be large. Maybe 2 percent of our business is from private insurance.

Copayments from non-Indians, which is again fairly insignificant, and then added very late in the President's bill, literally the last day, section 8314 establishes a kind of entitlement to the Indian Health Service for what would be known as premium discounts for unemployed and underemployed Indians. Essentially the IHS would have direct access to the Treasury for those amounts, and it is possible that half of the Indian population would be eligible for that kind of funding from that funding stream.

I think they will be very useful because we have not had any luck in the annual appropriations process dealing with a strictly discretionary program.

I would suggest, though, that I would add one small change to what is in section 8314. It talks about not a qualifying employee, that these benefits will be paid for someone who is not a qualifying employee, typically meaning unemployed, et cetera.

I would think it needs to be made sure in the Indian section that not a qualifying employee means that one being unemployed, partially employed, or underemployed would include a class of people that would be tribal employees and employees of tribal organizations, so that the funding for the discounts extended in the bill to those two classes of workers would come from this entitlement process as opposed to the discretionary process that we are now totally locked inside of.

Mr. WAXMAN. Well, I want to thank the three of you for your testimony. We will look forward to working with you to make sure that the goals of health security for every American applies to every American. Thank you so much.

Our next panel will discuss the impact of the President's plan on adolescents. Ms. Cecilia Cullen is the principal of Middle College High School in Long Island City, N.Y. Dr. Robert Blum is Professor, Director of General Pediatrics and Adolescent Health at the University of Minnesota. Ms. Julia Lear is the Director of Making the Grade: State and Local Partnerships to Establish School-Based Health Centers.

Without objection, your prepared statements will be in the record in full.

Ms. Cullen, why don't we start with you.

STATEMENTS OF CECILIA L. CULLEN, PRINCIPAL, MIDDLE COLLEGE HIGH SCHOOL, QUEENS, NY; JULIA GRAHAM LEAR, DIRECTOR, MAKING THE GRADE PROGRAM, ROBERT WOOD JOHNSON FOUNDATION; AND ROBERT WM. BLUM, DIRECTOR, DIVISION OF GENERAL PEDIATRICS AND ADOLESCENT HEALTH, UNIVERSITY OF MINNESOTA

Ms. CULLEN. I wrote this testimony on Tuesday of last week. We had buried an 18-year-old student that day. He was an 18-year-old Hispanic male who was about to graduate in June. He lived alone with his father and his 19-year-old mentally challenged brother. After he left school Thursday, he got into an argument with another youngster in his neighborhood. The other young man went home, got a gun, came back and shot him. He died in the arms of a fellow student.

I remember a time in group counseling when Freddie told another student to stop complaining about her mother because at

least she was lucky to have one. That is when we learned that Freddie's mother had died when he was 3 years old and his father was raising him and his brother alone.

Even though my students see a great deal of violence, when someone so young and close to them dies violently it has a devastating effect on them. Initially they are numb and do not comprehend what is happening. As the days pass, they experience more grief and tend to act out in various ways. I expect that we will probably have a few fights by the end of next week. Their feelings of hopelessness and futility are such that education seems trivial.

My guidance counselors are holding volunteer mourning groups during lunch periods. While I was attending the funeral, students gathered in the cafeteria to share remembrances of Freddie and a moment of silence. An art teacher will help students make a banner in memory of Freddie which will hang in the cafeteria. To expect the school to go on with business as usual in the face of such a tragedy is unreasonable. The mental health needs of the student have to be attended to before we can get them to the business of learning.

Thank God mourning the death of a student is not a regular occurrence at my high school, but it happens in some high schools every single day. Trained professionals are needed to help our students deal with the effects of violence, disease and dysfunction in their own families. Teachers have not been trained to deal with the extended emotional/mental health needs of today's teenagers. We also do not have the funds within the school budgets to meet these needs.

Because we have no choice, we will continue to address the mental health needs of our students in ways that we have learned from experience and intuition, but we are not spending our time doing what we were trained for—educating. Continuing under these circumstances, we will never meet the goals for education for the year 2000.

You might ask, why don't we refer students to mental health facilities? Adolescents will not go to outside agencies especially concerning issues of mental health. "What do you think, I am crazy, man?," pretty much summarizes the situation.

My school, Middle College High School, is an inner-city alternative high school for 500 students. We take students from western Queens and the South Bronx and provide them with classes on a college campus. The population is 50 percent Hispanic, 30 percent white and 20 percent African-American. The majority of my students have been designated as at risk because they are in danger of dropping out of school. But that label covers 60 to 70 percent of inner-city high school youth today.

On a daily basis the pedagogical staff see a variety of mental and physical problems in students. We estimate we spend 20 percent of our time tracking down services for our students.

Let me give you some examples. A year and a half ago, we realized that asthma is a major problem in our student body. We reviewed student records to identify and invite affected students to an asthma group run by a volunteer pediatric asthma specialist from New York hospital. To our dismay, we discovered we had 70

students diagnosed with asthma and we estimate there are an additional 20 who show symptoms but who have not been diagnosed. This constitutes almost 20 percent of our population.

Asthma has tremendous effects on the attendance of students. It is probably the number-one reason students are absent from my school. Cold weather alone keeps asthma sufferers out of school.

We have learned from this specialist that a great deal of the symptoms of asthma can be prevented with monitoring and support. In fact, Jessica, a 15-year-old Hispanic girl, used to have an asthma attack once a week that would require an ambulance to come to school. Since participating in this asthma group, Jessica has not had one attack in school.

At Middle College over 50 percent of my students have no health care coverage. Of the other 50 percent, 30 percent have Medicare and 20 percent come from families with coverage.

The needs of adolescents are very different from the needs of young children. Very young children tend to get taken to the doctor on a regular basis in order to satisfy the requirement of immunization. Older children do not have that requirement, and as a result parents do not take teenagers for regular check-ups.

Adolescents, being neither children nor adults, generally have no available clinics that meet their needs. Given the growth problems associated with adolescence, they feel very uncomfortable with their new bodies. If an emergency arises, as it often does with a teenager in New York City, they use the emergency room of the public hospitals which are committed to treat anyone who enters with medical need. It is not unusual for a young student who is not in a triage situation to wait more than 24 hours to get treatment. Because it takes so long to see a doctor in the emergency room, teenagers do not go for help. They wait until it reaches serious proportions before they seek help.

I had a student, Brian, in my class who had a broken thumb for 3 days while he waited to see a doctor to get it set. The clinics are open during the school day. Their parents can't take off to take them to the clinics.

We had a screening on high blood pressure, which is a common problem in teenagers in inner cities. Two of my students were told to come back because it wasn't an emergency and their parents could not afford to miss a day's pay. Other problems are tuberculosis, migraines, obesity, seizures and sexually transmitted diseases.

I think the only decision is to have school health-based clinics. It is the only way we can meet the special needs of this population and ensure they will all get the health care that they need. I think their health care is directly related to academic achievement, because it affects attendance. And we have to make it available for all of them if we are going to meet our goals for the year 2000.

[The prepared statement of Ms. Cullen follows:]

Testimony for Congressional Subcommittee on Health

Cecilia L. Cullen, Principal
Middle College High School
Queens, New York

January 18, 1994

We buried an 18 year old student today. Freddie Rios was an eighteen year old Hispanic male who was going to graduate this June. He lived with his father and his nineteen year old mentally challenged brother. After he left school on Thursday, he got into an argument with another youngster in his neighborhood. The other young man went home, got a gun, came back and shot him. He died in the arms of a fellow student. I remember a time in group counseling when a student was complaining about her mother and Freddie told her to stop complaining because at least she had a mother. That is how we found out that Freddie's mother died when he was three years old.

Even though my students see a great deal of violence, when someone who is young and close to them dies violently, it has a devastating effect. Initially, they are numb and do not comprehend what has happened. As the days pass they experience more grief and tend to act out in various ways. I expect that we will probably have a few fights by the end of the week. They have such feelings of hopelessness and futility that education seems trivial.

My guidance counselors are holding volunteer mourning groups during the lunch periods. While I was attending his funeral this morning the students gathered in the cafeteria to share remembrances of Freddie and a moment of silence. An art teacher will help students make a banner in memory of Freddie which will hang in the cafeteria, and will provide an opportunity for the students to express their grief. We will have a formal memorial ceremony in about two weeks. To expect a school to go on with 'business as usual' in the face of such a tragedy is unreasonable. The mental health needs of the students have to be attended to before we can expect them to get to the business of learning.

Thank God the death of a student is not a regular occurrence at Middle College, but it happens in some high schools every single day. Trained professionals are needed to help our students deal with the effects of violence, disease and disfunction in their own lives. Teachers have not been trained to deal with extended emotional/mental health needs of today's teenagers. We also do not have the funds within school budgets to meet these needs. Because we have no choice, we will continue to address the mental health needs of our students in ways we have learned from experience and intuition, however we are not spending our time doing the work we were trained for - education. Continuing under these circumstances, we will not meet the education goals for the year 2000.

You might ask why we do not refer students to mental health facilities. Adolescents will not go to outside agencies especially concerning issues of mental health. "What do you think, I'm crazy man?" pretty much summarizes the situation.

My school, Middle College High School, is an inner city alternative high school for 500 students. We take students from western Queens, and the South Bronx, and provide them with classes on a college campus. The population is 50% Hispanic, 30% white and 20% African-American. The majority of my students have been designated as "at risk" because they are in danger of dropping out of high school. That problem covers 60 to 70% of the student in inner city high schools today. On a daily basis, the pedagogical staff see a variety of mental and physical problems in students. Approximately 20% of their time is used trying to track down services for these students.

Let me give you some other examples; a year and a half ago, we realized that asthma is a major problem in our student body. We reviewed student records to identify and invite affected students to an asthma group run by a volunteer pediatric asthma specialist from New York Hospital. To our dismay we discovered that we had 70 students diagnosed with asthma. We estimate that there are an additional 20 who show symptoms but have not been diagnosed. This constitutes almost 20% of the population. Asthma has tremendous effects on the attendance of the students. Asthma is probably the #1 reason why students are absent from Middle College High School. Cold weather alone keeps asthma sufferers out of school so that they have a great many more days absent than other students. We have learned that a great deal of the symptoms of asthma can be prevented with monitoring and support. In fact, Jessica, a fifteen year old Hispanic girl used to have an asthma attack once a week that would require an ambulance to come to the school. Since participating in the asthma group, Jessica has not had one attack in school.

At Middle College over 50% of my students have no health care coverage. Of the other 50%, 30% have Medicare and the other 20% come from families that have coverage. The needs of adolescents are very different from the needs of young children. Very young children tend to get taken to a doctor on a regular basis in order to satisfy the requirement of immunization. Older children do not have that requirement and as a result parents do not take teenagers for regular check-ups. Adolescents being neither children nor adults generally have no available clinics that meet their needs. Given the growth problems associated with adolescence, they feel very uncomfortable with their new bodies.

If an emergency arises as it often does with a teenager in New York City they use the emergency room of the public hospitals which are committed to treat anyone who enters with a medical need. It is not unusual for a student who is not in triage to wait more than 24 hours to get treatment. Because it takes so long to see a doctor in an emergency room, teenagers do not go for help when they need

it. Instead they wait until it reaches serious proportions with pain and complications before seeking medical help. I had a student, Brian, in my class who had a broken thumb for three days while he waited to see a doctor to get it set. Using the emergency room for private care is ineffective and expensive. It ties up emergency rooms with many problems that could be handled in a doctor's office.

Emerson, a hearing impaired 19 year old student in my school does not miss any time from school. Two weeks ago he complained about being in pain. His teacher touched him on the back and was immediately concerned about the level of pain that he was suffering. She called an ambulance, got him to the hospital to discover that he had a collapsed lung. He waited so long to communicate this problem that he wound up being in a critical state for four days. If he had regular medical care his condition would not have reached a critical state.

Teenagers with emergency medical problems are given emergency treatment and told to come back for follow-up visits through the clinic; clinics only operate during the school day thus ensuring that the students miss more time from school. In addition because they fall between the pediatric and the adult clinic, adolescents do not feel comfortable and in fact their special needs are not addressed.

High blood pressure is another problem that is quite common among our student population. Genetic factors combined with a diet high in salt and fat create blood pressure problems that start in teenage years and escalate rapidly as the person grows older. In a screening program for high blood pressure provided by a van from New York Hospital, two of the fifteen students in my class were found to have high blood pressure. Both were given referrals to follow-up at a hospital clinic. Both did not attend. They did not attend because the visit requires that their parents take a day off from work to go with them. Parents cannot afford the loss of a day's pay to take students to clinics for preventative treatment. It would be so much easier to obtain parental permission to have the students treated on the school site.

In our population of 500 students probably 35 students get pregnant with five students giving birth each year. Those students are provided with medical care through a special program that we have with New York Hospital. Inevitably during their pre-natal care multiple health problems appear, usually asthma and high blood pressure. The fact that a teenager has to get pregnant before proper health care can be provided is deplorable.

Other common health problems that we see on a daily basis are allergies, diabetes, drug and alcohol abuse, tuberculosis, migraines, anorexia, obesity, seizures, sexually transmitted diseases and AIDS. It is my understanding that under the Clinton Health Care Reform Act schools will have health clinics. It is clear to me that a student's regular attendance at school is directly related to his achievement. By providing health care within the school facility, students will not miss time from school. I also believe that it is essential to have adolescent clinics to address the special needs of this population. Because of the fear and discomfort associated with their changing bodies and their unwillingness to go to outside referral agencies, I believe that adolescents can be best served by school health clinics. I believe that appropriate accessible health care is a critical component in our quest for having an educated work force by the year 2000.

Mr. WAXMAN. Thank you very much, Ms. Cullen.
Dr. Lear?

STATEMENT OF JULIA GRAHAM LEAR

Ms. LEAR. Mr. Chairman, I would like to ask unanimous consent, one, to add a table to my testimony which was inadvertently left out, and two, to request permission to replace the final page of my testimony at a later point. I realize there are some phrases that have been omitted that make some of this wonderful.

Mr. WAXMAN. Without objection, that will be the order. We will allow you to submit an additional statement or corrected statement.

Ms. LEAR. Thank you very much.

Mr. Chairman, my name is Julia Lear. I am very pleased to be invited to talk about the importance of including school-based health centers in Federal health care reform legislation, although I am going to state right now that I doubt I can present anything as compelling as Ms. Cullen. The experience of principals today is the greatest case to be made.

I am a member of the faculty at George Washington University and Director of the Making the Grade Program, a Robert Wood Johnson Foundation initiative to support State and local partnerships to establish school-based health centers. Over the past 15 years, the Johnson Foundation has supported health centers across the United States, and my comments today are meant to convey some of what we have been learning.

Your commitment and that of many other Members of Congress and the administration to health care reform is exciting, it is essential, and it really does represent a milestone in improving the ability of all Americans to secure health care, and we thank you.

My purpose in coming before you today is to join others in emphasizing that for some Americans, particularly for young people, ages 10 to 17, access to health care is going to require more than a health security card. That is why I was particularly pleased that the Clinton health care plan has made special efforts, through title III of the Health Security Act, to support the development of school-based health centers. These centers represent a recent but increasingly popular approach to expanding the availability of health care for school age children and youth.

As you are going to hear from my colleague, Dr. Blum, adolescents have enormous health care needs that are not being met by the traditional health care system, and I won't deal with that part of my testimony except to say that our experiences over the last 15 years is that school-based health centers do an excellent job of overcoming the organizational barriers that have inhibited delivering effective care to adolescents.

So let me talk a little bit about school-based health centers and what we have been learning and the implications for the reform legislation. During the past 20 years in communities across the United States, parents, school officials, health providers and public agencies have been testing the effectiveness of school-based health centers in providing care and responding to the particular needs of adolescents.

What was once seen as controversial and as a vehicle for sexually related services is now viewed in many areas as simply one of several ways in which we organize care for the obvious but unmet needs of young people.

School-based health centers began in two cities: in St. Paul, Minn. and Dallas, Tex. 20 years ago. They grew to 50 centers over the next decade, and then from 1983 to 1993 they grew from 50 to 500.

This expansion occurred without any direct Federal assistance. It occurred despite opposition from some community-based groups as well as national groups, who either objected to addressing contraception in a high school setting or were concerned that the health centers would come between parents and children.

However, the school-based health centers have continued to grow because the people most affected, parents and their children, have voted with their feet. Parents are signing the consent forms that allow their children to use the centers, and the children are going to those centers when they have need of services.

This past year, the increased support for school-based health centers was demonstrated when we did a survey of all the States to see what was happening in the State level for school-based health care. We did this jointly with the School Health Project of Columbia University. What we learned in the spring of 1993 was that 31 States have started programs to support school-based health centers, and then this past September when we began to receive the applications to the Making the Grade Program, we received letters from 38 Governors, plus the heads of government of the District of Columbia and Puerto Rico, all of which were requesting support for new State initiatives in school-based health care.

This widespread interest in school-based health centers and their relative newness and fragility makes us very concerned about how school-based health centers will be dealt with in the reform package. And so having looked at that, we have four primary recommendations that we would like to offer to you.

The first, and it has been said by others, is provide universal coverage. That is the most fundamental thing. Adolescents are the most uninsured group of Americans, and they will benefit greatly from universal coverage.

Moreover, by reimbursing providers for caring for adolescents, we are going to begin to address the second problem, which is there simply aren't enough providers right now willing to take care of adolescents.

However, as I noted, insurance is not enough. Organizational barriers exist. So the three additional recommendations concern the school-based health centers, and the first of those three points is to include startup support for school-based health centers. I noted that we are at 500 health centers without a Federal initiative. But there are 9,400 middle and senior high schools in this country in which 30 percent of the enrolled population is eligible for reduced or free lunch. That means a pretty poor population. And 9,400 compared to 500 indicates that there is a very large population of young people out there who very likely have the same kinds of needs as Ms. Cullen described, and school-based health

centers will make a difference. That won't happen without a Federal initiative.

I also want to suggest that the startup funds, however, not be put in the discretionary package. I think that will make a new program very vulnerable. I don't know enough about the specifics to argue whether it might be put into the area health plan as a required benefit or whatever, but I think some attention to the funding is very important to secure that.

The next recommendation is concerning mental health. It is an absolute—and I was glad to hear the point mentioned on mental health services—we have found. It is in table 10 in the testimony. Mental health services are the second-most demanded service in the school-based health centers that we have worked with.

It is——

Mr. WAXMAN. We are going to have to move on, Dr. Lear. Do you want to give me the fourth one, very quickly?

Ms. LEAR. The fourth will be a mandate for area health plans to negotiate with school-based health centers. Our experience with the managed care plans is without public encouragement, they will tend to try to exclude the school-based health centers.

Thank you.

[Testimony resumes on p. 157.]

[The prepared statement of Ms. Lear follows:]

STATEMENT OF JULIA GRAHAM LEAR

Over the past 12 years, I have assisted the Robert Wood Johnson Foundation in administering several of its national grant programs which have addressed the health care needs of adolescents -- both in community-based locations and in school-based health centers. My experiences in working with the 40 grant recipients of the three programs that follow form the basis for my comments concerning school-based health care and health care reform.

- From 1982 - 1986, the foundation supported 20 community-based programs for adolescents through its Program to Consolidate Health Services for High-Risk Young People.
- From 1987 - 1993, through The School-Based Adolescent Health Care Program the foundation supported the development of 24 school-based health centers through 18 grant awards to a variety of mainstream health care institutions whose school-based efforts were guided by local community and parent advisory groups.
- In 1993 the foundation launched a new initiative, Making the Grade, to assist state governments to reduce both organizational and financing barriers to school-based health care and provide stable funding. The program will also support the development of district-wide systems of school-based health centers in at least two communities in each state funded. This month the foundation awarded grants to 12 states to support a 15-month planning period. Grant recipients included Colorado, Connecticut, Delaware, Hawaii, Louisiana, Maryland, New York, North Carolina, Oregon, Rhode Island, Tennessee, and Vermont. In 1995, the Foundation will award 10 four-year grants to support implementation of the program.

The Robert Wood Johnson Foundation is the nation's largest health care philanthropy and was established as a national foundation in 1972. Over the past 15 years the Robert Wood Johnson Foundation has supported several national programs that have increased basic health care for children through school-based services.

Your commitment and that of many members of Congress and the Administration to health care reform is exciting and represents a milestone in improving the ability of every American to secure health care when he or she is sick.

My purpose in coming before you today is to join others in emphasizing that for some Americans, particularly for some young people ages 10 - 17, access to health care will require more than a Health Security Card. That is why I was very pleased to see that the Clinton plan has made special efforts, through Title III of the Health Security Act to support the development of school-based health centers. These centers represent a recent and increasingly popular approach to expanding the availability of health care for school-age children and youth.

Adolescents have had well documented difficulties in securing access to care -- as an age group they have the highest rate of uninsured individuals; they have the fewest visits to the doctor; nearly half those visits last 10 minutes or less, and if they do see a provider, it is unlikely that provider has been trained particularly in adolescent health care.

The limited contact between adolescents and the health care system should not be taken as evidence that adolescents do not need care. As reported by the Office of Technology Assessment, one of five adolescents suffer from at least one serious health problem, 5 - 10% have a chronic disease or disability such as asthma or heart disease or vision problems, and a much larger number (20 - 50%) are estimated to experience a range of less serious problems. In addition, one in four adolescents is believed to be at high risk for school failure, delinquency, early and unprotected sexual intercourse and substance abuse. Table 1 summarizes recent data from the Centers for Disease Control and Prevention that underscore the importance of these problems.

During the past twenty years, in communities across the country, parents, school officials, health providers and public agencies have begun to test the effectiveness of school-based health centers in providing care and responding to the particular needs of adolescents. What was once seen as controversial and as a vehicle for sexually-related services is now viewed in many areas as simply one of several ways in which communities try to address the obvious, yet unmet needs of adolescents.

School-based health centers began in two cities -- St. Paul, Minnesota and Dallas, Texas -- just over 20 years ago. They grew to 50 health centers in the 12 years that followed; and then grew from 50 to 500 in the decade beyond that.

A number of factors have contributed to the astonishing acceleration in the development of school-based health centers:

- The rate of child poverty increased during the 1980s, leading to governmental interest in offsetting the negative health and educational achievement consequences of poverty;

- Concern that too many young people were leaving school untrained to contribute to the workforce of the 21st century and an increased awareness that school success is linked to children being "ready-to-learn" spurred recommendations that health and other services be brought on campus;
- Adolescent problems, especially premature mortality due to automobile accidents, homicide and suicide; continued high rates of sexually transmitted disease and increased risk for HIV infection; sustained high rates of heavy alcohol use as well as health system barriers to addressing these problems encouraged efforts to find new ways of providing care to teens;
- Political opposition to health services delivery in school declined: first, because the advent of AIDS and fear of HIV infection has made parents and communities more willing to face the reality of adolescent sexual activity, and second, because increases in the number of salaried physicians, managed care arrangements and HMOs have made new ways of organizing health services more acceptable among health professionals, and
- The emergence of mid-level practitioners -- nurse practitioners, physician assistants, and clinical social workers, their growing acceptability to patients, and their lower cost has made possible the development of cost-effective health care teams based in schools.

While not all school-based health centers are alike, there is consensus that the ideal center is multi-disciplinary, offers both physical and mental health services, emphasizes prevention as well as treatment, works in partnership with the school, and requires parental consent. (See Table 2)

From 1987 until 1993, 24 school-based health centers supported through the Johnson Foundation's School-Based Adolescent Health Care Program reported on their experience in some detail. As indicated in Tables 3 - 13, data from those centers confirmed reports from earlier centers that school-based health centers could provide accessible, affordable health care to poor children. Key findings from the Program include the following:

Health centers are popular with parents -- more than 70 percent of parents consent for their children to use the clinics. (Table 3)

Health centers are popular with students. 45% of the enrolled students use the clinics and the average visit rate is 4 visits per year per student (Table 4). That the clinics are popular with students is demonstrated also by the high ratio of repeat visits to new visits. (Table 4a)

The health centers have increased access to care for young people who do not have access to regular providers (Table 5), who have not seen a physician lately (Table 6), and who do not have health insurance (Table 7).

Health center users reflect the age (Table 8) and ethnicity (Table 9) of students enrolled in the schools .

Health services provided at the school are comprehensive and include a range of physical and mental health services (Table 10). Note that the leading services provided were care of acute illnesses and injuries (29%), mental health (18%), and physical examinations (15%). Reproductive health care accounted for 10% of the services. The diversity of student needs and health center services were confirmed by a similar report from the Columbia University School Health Policy project. (Table 14)

The intensity of patient visits is suggested by both the length of patient visits and the numbers of prescriptions (Tables 11 and 12).

Most school-based health centers provide health education and health promotion services in school classrooms, at health fairs for school sport teams and for the parent and faculty organizations (Table 13).

The promising data that began to emerge from school-based health centers such as those funded by The Robert Wood Johnson Foundation fueled the remarkable expansion that occurred nationally -- despite the absence of direct federal support and despite sporadic opposition from some community-based as well as national groups that objected to addressing contraception in a school location or were concerned that health centers would come between parents and their children. In the end, support from parents who approved their children using the health centers and support from children and young people who sought care at the clinics eased concerns regarding their acceptability.

This past year our office, together with the Columbia University School Health Project, surveyed all fifty state governments to learn whether they were involved in school-based health care initiatives. As of the Spring of 1993, 31 of the 50 states had initiated programs to develop school-based health centers. And this past summer, in response to The Robert Wood Johnson Foundation announcement of grants for the Making the Grade Program, 38 state governors plus the heads of the District of Columbia and Puerto Rican governments signed letters requesting that their jurisdictions be funded to develop new state programs in school-based health care.

This widespread interest in school-based health centers and the relative newness of these efforts makes us particularly interested in examining how health care reform will take into account these very promising vehicles for providing care to

adolescents. The following points summarize features that will make health care reform plans supportive of good school-based health centers:

- Universal access. Adolescents are the most uninsured group of Americans. They will benefit greatly from any plan that assures them coverage. Moreover, by reimbursing providers for adolescents' care, over the long run we will see more providers taking care of teens.

For example, at Far Rockaway High School in Queens, New York, 66% of the students treated at the school-based health center have no insurance coverage.

- Start-up support for school-based health centers. Currently, 500 schools have school-based health centers but there are 9,400 middle and senior high schools in which 30% or more of the students are poor enough to be eligible for free or reduced price lunches. To meet the needs of a substantial number of the children who need care, federal funding is essential.

A concern is where the money for the school-based health centers start-up will come from. I would recommend that this support be assured by folding it into the health care financing package rather than placing the start-up funds in the discretionary budget.

- Recognition of the importance of local conditions and building on local resources. Nationally, schools and communities vary enormously in terms of students' needs, community resources, and parents' interests. Local factors need to be determinative.
- On-site care for physical health, mental health and substance abuse problems. As has been said many times, students don't travel well and they don't carry appointment books. If we want to get services to adolescents, we will need to take those services to them.

As was demonstrated by data from the School-Based Adolescent Health Care Program and the Columbia University School Health Policy Project, mental health services were the second most demanded service, following acute care. Moreover, few communities have adequate existing mental health resources to treat adolescents and, as noted above, adolescents are particularly reluctant to follow through on mental health referrals.

- Participation by a variety of community providers. School-based health centers participating in the School-based Adolescent Health Care Program have been successfully organized by hospitals, health departments, community health centers, and teaching hospitals. Other entities such as HMOs and group practices might also organize school-based health centers.

- Participation of school-based health centers in area health plans. The experience of school-based health centers in negotiating with managed care providers suggests that it will be important to mandate that all school-based health centers be brought under the essential community provider umbrella. The experience of school-based health centers in St. Paul, Minnesota and Baltimore, Maryland has been that it is not easy to secure reimbursement from managed care providers for services delivered to their adolescent patients.

In an ideal system of health care for young people, primary physical and mental health services can be delivered in schools and linked closely to other parts of the health care system both for after-hours care as well as for specialty care. To offer such a comprehensive net of services to young people holds the promise of ending a long period of malign neglect which has imperiled adolescents' future and offers the hope of repairing the damage.

TABLE 1

Behavioral Risk Factors Among High School Students in the United States, 1991

Ever had sexual intercourse	54%
Had sexual intercourse with 4 or more partners	19%
Smoked cigarettes past 30 days	28%
Used marijuana past 30 days	15%
Had 5 or more drinks on one occasion past 30 days	31%
Were in physical fight past year	42%
Carried a weapon past 30 days	26%
Did not always wear safety belts	72%
Had 5 or more servings of fruits & vegetables yesterday	13%
Not enrolled in physical education	51%
Attempted suicide past year	7%

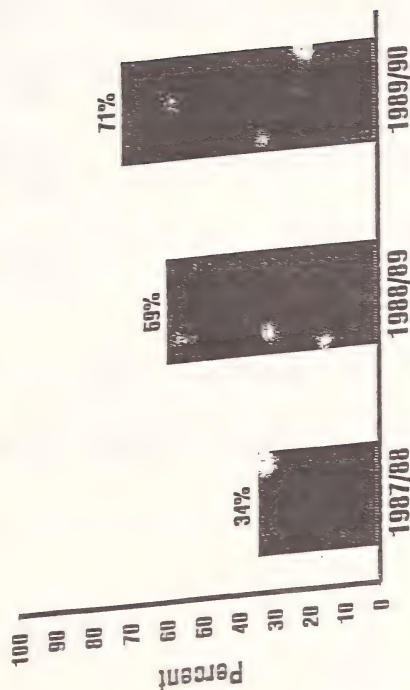
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TABLE 2

School-Based Health Center Model

- Located in school or on school campus
- Parental consent policy required
- Overseen by advisory board composed of community reps, youth, parents, other appropriate individuals or agencies
- Cooperative linkages with school nurses, teachers, coaches, school administration
- Staffed by multidisciplinary team of nurse practitioners, clinical social workers, physicians and other health professionals
- Provides a comprehensive range of services to meet the serious health problems of young people in the community as well as provide general medical care

Source: School-based Adolescent Health Care Program, The George Washington University, Washington, D.C. 1993.

SCHOOL-BASED ADOLESCENT HEALTH CARE PROGRAMPERCENTAGES OF STUDENTS WHOSE PARENTS
CONSENTED TO CARE

Source: School-based Adolescent Health Care Program, The George Washington University, Washington, D.C. 1993.

**TABLE 4. SCHOOL ENROLLMENT AND
CLINIC UTILIZATION**

	School Population	Clinic Users	Total Visits	Visit Rate
1989/1990 ^a	34,106	15,748 (46%)	59,069	3.7
1990/1991 ^a	33,672	14,453 (44%)	61,454	4.1
1991/1992 ^b	37,189	16,650 (45%)	66,481	4.0

^a 23 school-based health centers

^b 24 school-based health centers

Source: School-based Adolescent Health Care Program,
The George Washington University, Washington, D.C., 1993

TABLE 4a. PATIENT VISIT DATA

	1988/ 1989	1989/ 1990	1990/ 1991	1991/ 1992
Total Visits	49,337	59,069	61,454	66,481
Repeat visits	81%	84%	86%	84%
New visits	19%	16%	14%	16%

Source: School-based Adolescent Health Care Program, The George Washington University, Washington, D.C. 1993.

TABLE 5

ACCESS TO HEALTH CARE FOR NEW PATIENTS

Previous routine source of care	1988/ 1989	1989/ 1990	1990/ 1991	1991/ 1992
Physician/clinic	63%	72%	52%	54%
Emergency room	8%	8%	7%	9%
No regular source of care	29%	21%	41%	36%

Source: School-based Adolescent Health Care Program, The George Washington University, Washington, D.C. 1993.

TABLE 6

ACCESS TO HEALTH CARE FOR NEW PATIENTS

Most recent medical care	1988/ 1989	1989/ 1990	1990/ 1991	1991/ 1992
Within 1 year	59%	58%	59%	44%
1-2 years	22%	21%	21%	27%
2+ years	19%	21%	20%	29%

Source: School-based Adolescent Health Care Program, The George Washington University, Washington, D.C., 1993

TABLE 7

ACCESS TO HEALTH CARE FOR NEW PATIENTS

Insured status	1988/ 1989	1989/ 1990	1990/ 1991	1991/ 1992
Medicaid	24%	18%	20%	30%
Private insurance	27%	25%	19%	23%
Self Pay	49%	58%	62%	48%

Source: School-based Adolescent Health Care Program, The George Washington University, Washington, D.C. 1993.

TABLE 8
PATIENT VISITS BY AGE

	1988/ 1989	1989/ 1990	1990/ 1991	1991/ 1992
13 and under	8%	6%	6%	9%
14-15	33%	29%	31%	29%
16-17	43%	49%	49%	46%
18-19	17%	12%	13%	14%
20+	<1%	1%	1%	1%

Source: School-based Adolescent Health Care Program, The George Washington University, Washington D.C. 1993.

TABLE 9
PATIENT VISITS BY RACE/ETHNICITY

	1988/ 1989	1989/ 1990	1990/ 1991	1991/ 1992
Asian	2%	1%	3%	2%
African American	56%	57%	51%	55%
Hispanic	21%	19%	26%	25%
Non-Hispanic white	19%	20%	18%	16%
Other	3%	3%	3%	2%

Source: School-based Adolescent Health Care Program, The George Washington University, Washington, D.C. 1993.

TABLE 10

HEALTH SERVICES PROVIDED*

	1990/ 1991	1991/ 1992
Acute illness	32%	29%
Chronic health problems	6%	6%
Acne, other skin problems	4%	4%
Physical exams	13%	15%
Mental health	14%	18%
Reproductive health, STDs, family planning	9%	10%
Prenatal care	2%	1%
Nutrition, eating disorders	4%	3%
Drug/alcohol abuse	2%	2%
Other, incl. immunization, vision, hearing	14%	12%

*Primary service/diagnosis only

Source: School-based Adolescent Health Care Program, The George Washington University, Washington, D.C. 1993.

TABLE 11

PATIENT VISITS BY LENGTH OF VISIT

	1988/ 1989	1989/ 1990	1990/ 1991	1991/ 1992
Less than 10 minutes	24%	21%	19%	14%
10-20 minutes	34%	28%	34%	30%
More than 20 minutes	42%	51%	48%	56%

Source: School-based Adolescent Health Care Program, The George Washington University, Washington, D.C., 1993.

TABLE 12

PRESCRIPTIONS WRITTEN OR DISPENSED

1988/ 1989	1989/ 1990	1990/ 1991	1991/ 1992
6,939	7,158	10,575	10,500*

*One project not reporting.

Source: School-based Adolescent Health Care Program,
The George Washington University, Washington, D.C. 1993.

TABLE 13

PARTICIPATION IN EXTRAMURAL ACTIVITIES
BY ACTIVITY TYPE* - 1990

	Participating projects (n)
Classroom health education	16
School-wide health fairs	9
School-wide immunization programs	8
PTA/other parent education	7
Non-clinic sports/other physicals	6
School-wide crisis intervention teams	5
Teacher education	5
Drop-out prevention	5

*Activities reported by 18 program grantees.

Source: School-based Adolescent Health Care Program, The George
Washington University, Washington, D.C. 1993

TABLE 14

FREQUENCY OF DIAGNOSTIC CATEGORIES SEEN IN SELECTED SCHOOL-BASED
HEALTH CENTERS WITH COMPREHENSIVE CAPACITY

	Connecticut Elementary	New York Middle School	New York High School	Colorado High Schools (2)
Grade Level	K-8	6-8	9-12	9-12
# Students in School	1,200	1,700	1,700	3,926
# Enrollees in SBHC	968	668	1,000	2,595
# SBHC visits/year	1,612	2,942	5,214	7,590
Total # diagnoses/year	1,612	2,942	5,942	7,590
Diagnostic Category	Total %	Total %	Total %	Total %
Well Child/Adolescent	6%	15%	19%	14%
Gynecology/Sexuality related	2%	4%	24%	9%
Mental Health/Social Work	36%	26%	16%	42%
Infections	14%	6%	6%	6%
Injury/Orthopedic	4%	6%	5%	4%
Neuro/Ophthalmology		8%	3%	2%
Cardio/Respiratory	0%	4%	4%	2%
Endocrine/Obesity	<1%	2%	2%	<1%
Dermatology	6%	3%	3%	3%
Hematology	<1%	2%	3%	<1%
Gastroenterology	4%	4%	5%	1%
Dental	2%	15%	8%	<1%
Urologic	--	1%	--	1%
Ear/nose/throat	1%	3%	3%	2%
Allergic	<1%	<1%	<1%	<1%
Drug and Alcohol Services	--	--	--	14%
Unknown	7%	2%	--	<1%

Source: Columbia School Health Policy Project, Special Report: Defining School-based Health Center Services, December 1993. P.30.

Mr. WAXMAN. Thank you very much.
Dr. Blum?

STATEMENT OF ROBERT WM. BLUM

Mr. BLUM. Mr. Chairman, before I begin, I would like to request permission to make some minor revisions in my text for the record and submit that.

Mr. WAXMAN. We would be pleased to receive it. Thank you.

Mr. BLUM. Good afternoon. I am Robert Blum. I am Professor of Pediatrics at the University of Minnesota. I am a clinician, a father of two adolescents, and an academican in the field of adolescent medicine and adolescent health. It is that set of experiences I bring to the table today.

I want to speak about adolescents not simply about from the perspective of the problems and the issues. Too often we tend to focus on the major health problems, juvenile violence, which we have heard so graphically discussed, sexually transmitted diseases including AIDS, substance abuse, precocious parenthood—youth are faced with a much wider set of issues. Six percent of all adolescents have a chronic or disabling condition that limit their activities of daily living. About one in five suffer significant depression, and 15 percent, about one in seven, will have attempted to kill themselves at least once during their teenage years. This age group is also the most rapidly escalating in poverty levels of any group in the United States.

Equally important to the problems that young people face are the opportunities. For it is a stage in life when many health habits are being formed—habits including tobacco use, alcohol use, nutrition and exercise. These are but a few examples that, if ignored, create costly health problems.

And I listened in wonderment this morning as people talked about the cost of provision of services as if there were no costs to the nonprovision of health services. We pay exorbitantly for the nonprovision of health services. Likewise, stress management, conflict resolution and assertiveness skills, while these are not ostensibly health concerns, rapidly become so when we look at the morbidity and mortality that come from our failure to address these issues: depression, chronic pain, suicide, homicide, intentional injuries, child abuse, pregnancy and sexually transmitted diseases are but a few very costly issues.

The Clinton Health Security Act appropriately places its emphasis on preventive and health promoting strategies. It places health care where it belongs—in the primary health care setting. But given the unique needs as well as the opportunities of adolescents, I would like to offer a few recommendations.

One deals with financial barriers. Financial barriers to services, especially preventive and primary care services, are counterproductive. Given the vulnerabilities teenagers already feel in seeking services, financial barriers will only perpetuate the inherent inclination to delay seeking care. For those in poverty, one in five of all teenagers, this is even more problematic.

Thus, I would recommend, A, that the copayment requirement be eliminated for those below 200 percent of poverty. And B, copayments by adolescents be eliminated for those services pro-

tected by Federal or State statute as confidential. And C, copayments should be adjusted for total use and is not totally episodic visits so as to account for the long-term care needs for those with chronic and disabling conditions for which we have heard testimony today.

Second, perhaps the most severely limiting of all aspects of the Health Security Act as it currently stands are the provisions for children who are the most vulnerable in our society, those with chronic and disable conditions. In the name of promoting primary care, we cannot leave these children so exposed. Neither can we restrict habilitative services to those with acquired illnesses or disabilities. Allen Bergman spoke about this issue this morning, that the Health Security Act as it currently stands excludes those with acquired disabilities. It likewise denies habilitative services for those where there is a maintenance level that is achieved, and it restricts it to those for whom only improvement of services occurs.

The third area relates to confidential services. While there is concern that adolescents wish to keep their health issues secret, the reality is most teenagers do speak with their parents, do tell them their concerns, and do seek their advice, even for issues related to family planning services.

On the other hand, for some adolescents there are certain health concerns and problems for which they will forego treatment rather than risk exposure, and thus access to confidential services is *sine qua non* for all adolescent health care.

In truth, adolescents already believe that the world is watching them. That is why they spend so much time combing their hair. Another reality is that it is just those health concerns that place young people at greatest risk, mental health, physical abuse, sexual and reproductive health and substance abuse, for which confidentiality is essential to seeking services.

Fourth and finally, a strong public health infrastructure. A strong public health infrastructure is essential to the successful implementation of the Health Security Act, especially as it relates to continuous quality assurance as well as assurance of equity of services for vulnerable populations. For youth, title V has historically been the essential Federal agency for oversight, training and research, and while other agencies have addressed categorical issues, the Maternal and Child Health Bureau has explored systems of change through demonstration projects, has supported training through its adolescent training grants, and has facilitated the establishment of State level capacity in adolescent health to developing a network of State adolescent health coordinators. I would encourage strengthening the functions represented by that public health authority.

Thank you for giving me this opportunity.

[The prepared statement of Mr. Blum follows:]

Robert Wm. Blum, M.D., M.P.H., Ph.D.
Professor and Director
Division of General Pediatrics and Adolescent Health

Good morning my name is Robert Blum and I am a Professor of Pediatrics at the University of Minnesota where I direct the Division of General Pediatrics and Adolescent Health. I am a parent of three children, two of whom are adolescents, and the other a teenager-in-training. I have recently served as President of the Society for Adolescent Medicine and while I speak for myself, I know that the ideas I present reflect the opinions of many of my colleagues. I speak to you as a clinician, as an educator, and one vitally interested in the implications of health care reform for the health and well being of young people. The suggestions I will offer are based upon a recent working group meeting held in Washington where the focus was on adolescence and health care reform.

Adolescence is a unique developmental stage distinct from both childhood and adulthood. Not only is it a transitional period, it is a distinct stage of life with special vulnerabilities and health concerns. While we tend to focus on major public health problems such as juvenile violence, sexually transmitted diseases including AIDS, substance abuse and precocious parenthood, youth are faced with a much wider set of health risks. Six percent have chronic or disabling conditions that limit their activities of daily living. One in six will experience significant depression with nearly 15% of teenagers attempting to kill themselves during their adolescent years. This is also the age group with the most rapidly escalating levels of poverty of any in America.

Equally important to the problems facing youth is the reality that adolescence is a time of opportunity. It is the stage of life when many health habits are being formed—habits concerning tobacco use, alcohol use, nutrition and exercise are but a few examples which can relate to severe and

costly adult health problems if health promoting habits are not instilled early. Likewise, stress management, conflict resolution and assertiveness skills while not ostensibly health concerns rapidly become so when we look at the litany of morbidity and mortality that stem from our failure to address those issues: depression, chronic pain, suicide, homicide, intentional injuries, child abuse, pregnancy and sexually transmitted disease are but a few. These are profoundly costly and to a great extent avoidable social morbidities in adolescence and adulthood.

The Clinton Health Security Act appropriately places its emphasis on preventive and health promoting strategies. The universal coverage provision and the basic benefit package with its focus on primary care services for youth as well as for all Americans emphasizes health care provision where it most appropriately belongs — in the primary care setting. However, given both the unique needs as well as opportunities of this age group the following recommendations are offered.

#1 Confidential Services

While there is concern that adolescents wish to keep health issues secret, the reality is that most young people *do* tell their parents and seek their advice even for issues such as family planning services. On the other hand, for some adolescents there are certain health concerns and problems for which they will forego treatment rather than risk exposure; thus, access to confidential services is a sine qua non of adolescent health care. This is true not because teenagers wish to avoid speaking with their parents; rather, given the vulnerability they feel, teenagers need to have the assurance that they are in control of whom they tell. In truth, adolescents already believe

that the world is watching them — that is why they spend so much time combing their hair. Another reality is that it is just those health concerns that place young people at greatest risk — including mental health, physical abuse, sexual and reproductive health, and chemical health — for which confidentiality is *central* to seeking services. Failure to provide a mechanism for access to confidential services risks the health of both the individual and the community. Such failure manifests itself in increased costs and increased injury resulting from foregoing needed services.

#2 Financial Barriers

Financial barriers to services — especially preventive and primary care services — is counterproductive. Given the vulnerability teenagers already feel in seeking services, financial barriers will only perpetuate the inherent inclination to delay seeking care. For those in poverty — 20% of the adolescent population — this is even more problematic. Thus, I would recommend: a) the co-payment requirement should be eliminated for those below 200% of poverty; b) co-payments should be adjusted for total use and not solely episodic visits so as to account for those with chronic and disabling conditions, and c) co-payments by adolescents be eliminated for those services protected by federal or state statute as confidential.

#3 Improved Services for Those Young People with Chronic and Disabling Conditions

One of the most severe limitations of the Health Security Act is the provisions made for those children who are the most vulnerable in our society. In the name of promoting primary care we cannot leave such children so exposed. Specifically, we need to assure that a wide range of

services are available to young people who have long-term care needs. Whether this is done through special provisions in the Health Security Act or through supplemental programs such as EPSDT is an issue of methodology. At a minimum the supplemental package should include:

- Long-term occupational therapy, speech-language pathology services, respiratory therapy, and physical therapy;
- Care coordination or case management services;
- Specialized nursing services, including in-home nursing care;
- Mental health services related to the treatment of chronic health problems;
- Custom-designed durable medical equipment, prosthetic, orthotic and adaptive devices, including assistive technology;
- Personal care services needed in conducting the activities of daily living;
- Respite care for family care takers; and
- Patient and family education and training related to a child's treatment needs.

#4 A Strong Public Health Infrastructure

A strong public health infrastructure is central to the successful implementation of the Health Security Act especially relating to continuous quality assurance as well as assurance of equity of services for vulnerable populations. For youth, Title V has historically been the central federal agency for oversight, training and research and while other agencies have addressed categorical issues ranging from disabilities, teen pregnancy, STD surveillance and substance abuse, the Maternal and Child Health Bureau has explored systems of change through its demonstration projects, supported

training in adolescent health through training grants and has facilitated the establishment of state-level capacity in adolescent health through developing a network of state adolescent health coordinators. I would encourage strengthening the functions represented by that public health authority.

In summary, the Health Security Act is a great step forward for young people as it is for all Americans. For youth, their special needs and opportunities require more complete consideration of the issues related to: confidentiality, co-payments, needs of youth with chronic and disabling conditions and a strong Maternal and Child Health Bureau. Thank you for giving me the opportunity to address you this morning.

Mr. WAXMAN. Thank you very much.

I want to thank the three of you for excellent testimony.

On this issue of confidentiality, this committee has debated the importance of confidentiality for minors seeking abortion services, but you have raised the issue of a number of other health issues, such as mental health or substance abuse. How important is the confidentiality of services for adolescents when it comes to this whole range of different services that they may receive?

Mr. BLUM. Let me touch briefly on those issues. There is an assumption that is ill-founded that if parents are notified in advance of a minor seeking—desiring an abortion, that they will dissuade their minor from seeking those services. The data is clearly in the opposite direction. As many parents compel their minors to have abortions as deny them.

We undertook the largest study of minors with abortion in the United States. We compared Minnesota with Wisconsin and found that a parental notification law does not increase by more than one tenth of 1 percent parental notification at any age at any time.

It is impossible by mandate to compel. What you do wind up doing, however, is deny access to services. And this we have seen. There is good evidence in areas of not only reproductive health but in mental health and particularly in substance abuse that it results in delaying acquisition of services, and particularly seeking early intervention services, when young people may have a suspicion of concern or even more important when their parents have concern about their behavior, that parents, if they must first have approval, the process can be delayed months or years.

Mr. WAXMAN. As I recall, in Minnesota you have a very strict parental notification law, and the data, as I recall, was that there were fewer pregnancies, unwanted pregnancies among minors. Is that a correct statement, do you recall?

Mr. BLUM. The statement is correct, but when you look at the data nationally, at the trends, and you are referring to this study by Cleary, the trends are pretty parallel to the rest of the country. The evidence is questionable at best that that abortion law has significant impact on reducing abortion. And it certainly has not had an impact in terms of increasing parental notification, particularly when you compare it to Wisconsin, which is demographically identical in so many ways, except Wisconsin, when we undertook this in 1984 and 1985, did not have a parental notification law, and the patterns of parental notification from 13 through 17 are absolutely identical for the two groups.

So I feel that one is hard pressed to view that law as having a significant impact at all on parental notification.

Mr. WAXMAN. Thank you.

Ms. Cullen, some people characterize school-based clinics as only a site for giving out contraceptives and referring for abortions. If you had such a service, are those the only services you would provide?

Ms. CULLEN. Absolutely not. We have a higher incidence of asthma than pregnancy. There are so many problems that need to be addressed at this age level that go beyond counseling or planning for pregnancy, birth control.

Mr. WAXMAN. Thank you.

Dr. Lear, I note the Robert Wood Johnson Foundation has a lot of experience in these programs and you have looked at school-based clinics nationwide. Some people characterize school-based clinics, as I indicated, as only contraceptive and abortion services. What has been your evaluation of these programs around the country?

Ms. LEAR. In the school-based adolescent health care program, grantees' 24 school-based health centers, reproductive health care constituted 10 percent of all services. Acute care was the leading service demanded. And our experience is reflected in non-RWJ-funded, school-based health centers. It was a significant small part of what is offered.

Mr. WAXMAN. You indicate in your testimony that the number of school-based clinics has increased by 1,000 percent over the last 10 years. I suspect some people might ask if this is such a popular program, why does the Federal Government have to provide support rather than leaving it just to the foundations and the State and local governments. How would you respond?

Ms. LEAR. Well, in talking about the number of simply middle- and senior-high schools, and I should say that I left out the elementary schools, there are many communities which feel very strongly that they could use school-based health centers for younger children as well. We are just a drop in the bucket.

The fact is, all over this country there are large numbers of children with multiple kinds of needs who need the diverse range of services available at a school-based health center, the mental health as well as the physical health. And without Federal support, as large as the Robert Wood Johnson Foundation's resources are, there is no way we will really help the number of children who need it.

Ms. CULLEN. I have been trying to get one, and I estimate about \$25,000 to put one in. Robert Wood Johnson is not giving out money anymore and the State is waiting to see what happens with the Clinton health care reform before they make a decision as to whether they are going to go ahead with it. So there is definitely a need for Federal funding of this. We do not have the wherewithal on the local level to start these up.

Mr. WAXMAN. Well, I thank the three of you very much for your testimony. I think you have given us terrific testimony, it will be useful for the committee.

Our next panel will talk about the health status and needs of racial and ethnic minorities and how these needs are addressed by the Clinton plan.

Our witnesses are Dr. Elena Rios, chairperson of the Latino Coalition on Health and a physician from California; Dr. Elizabeth King, chairperson of the Health Policy Committee of the National Medical Association and a physician from New York City; and Tessie Guillermo, Director of the Asian American Health Forum in San Francisco. We are pleased to have the three of you here.

Your prepared statements will be in the record in full without objection, and we would like to ask you to limit the oral presentation to no more than 5 minutes.

Dr. Rios, why don't we start with you.

STATEMENTS OF ELENA V. RIOS, CHAIRPERSON, LATINO COALITION ON HEALTH; ELIZABETH KING, CHAIRPERSON, HEALTH POLICY COMMITTEE, NATIONAL MEDICAL ASSOCIATION; AND TESSIE GUILLERMO, EXECUTIVE DIRECTOR, ASIAN AND PACIFIC ISLANDER AMERICAN HEALTH FORUM

Ms. RIOS. Congressman Waxman, members of the committee, guests, thank you for having us here. I represent the Latino Coalition on Health which is a national organization representing national and regional organizations interested in improving the health care system for Latinos and other underserved communities. We have seven principles, and I will just briefly make comments about the Health Security Act based on each of the seven principles:

Number one is universal access. We feel very strongly that access has to be given to not only the undocumented in our country, but all residents, including the residents of the Island of Puerto Rico, which we feel needs to be addressed more clearly. Other access issues include cultural competency in the language within all of the information in our act.

The definition of family should be expanded to include common-law married couples and extended family members living in a single household. Reduction in cost sharing for low-income families in the plan will be limited by health alliances if they so determine that there are low-cost health plans within their area. And we feel that that limitation should be dropped.

Number two is benefits. We support guaranteed benefits and we would include or expand those benefits to target our community, specifically diabetes, women's health care, HIV, et cetera, that target our Latino communities.

Three is governance. We are very interested in participating in the policy process and maintaining that process participation at all levels, national, local level.

Number four is that we know that the States have to have flexibility to be responsive to their needs. Two examples, in particular for the Latino communities: Number one is the U.S.-Mexico border needs to be addressed, and we think it should be a binational strategy; and number two is the migrant populations in our States needs to have adequate funding.

And number five is the funding for community-based health facilities and networks of physicians must be expanded. The community health centers which are the systems in our low-income communities need to be pumped up in terms of funding. Also, we need to have effective measures for incentives for our physicians and providers, not merely a \$1,000 tax credit or some low-interest seed money, but we need long-term, low-interest loans.

The major flaw in the Clinton plan in terms of the underserved is the definition of the underserved, that the area will only be based on providers, the health professional shortage areas. We think that they should—the areas need to be looked at in terms of the high risk and the income level of the people in those communities.

Health services for the medically underserved, all the access initiatives, again we need long-term commitments, low-interest loans.

School-based clinics, we really agree that we need school-based clinics. However, why create another bureaucracy and put the money into the educational system? Why not give the funding to the providers that can best provide the health services in the schools?

And number six is the data collection and accountability in the system. We need to expand our knowledge on the population, such as Latinos. We have only recently had that in our census and we need ethnic identifiers in all data collection for this health system to be effective.

We also need accountability that will monitor all of the low-income communities that we don't have presently, accountability to take care of fraud and abuse that runs rampant in poor communities because they can be taken advantage of by providers or other people both from without the community and from within the community.

And number seven and lastly, we need more Latino health providers. The underrepresented Hispanics that get into medical schools right now, it is great to have recruitment and retention programs, but the government only recognizes that the underrepresented Hispanics are Mexican-American and mainland Puerto Rican. We think all Hispanics should be underrepresented in our medical schools.

We need coordination and monitoring of all the Federal programs. We have had a plateau of the numbers of minorities in our medical schools since 1975, and we feel that there is a lack of evaluation and monitoring and that needs to be corrected.

Also, the funding for our health work force needs to be directed to the grammar school and high school levels of science and math and not merely the college recruitment programs.

And in terms of faculty development, I just want to say that the Hispanic Centers of Excellence, not mentioned at all in the Clinton health bill, need to be funded, because that is the center for faculty development and research that our communities so greatly needs. And minority faculty, one last thing, I think that the minority faculty should be in community clinics, not just limited to academic health centers, as the Federal Minority Faculty Development Program is currently.

Thank you.

Mr. WAXMAN. Thank you very much.

[The prepared statement of Ms. Rios follows:]

STATEMENT OF ELENA V. RIOS

INTRODUCTION

Congressman Waxman, members of the Subcommittee on Health and the Environment, staff, and guests, I am here today representing the Latino Coalition on Health - a coalition of national and regional organizations interested in improving health care delivery to Latinos in the United States.

I am here today to discuss health care reform that has the following goals : equity, justice, accountability, and resource development. The Latino Coalition on Health believes that Congressional Committees have the opportunity to be responsive to all Americans as you discuss health reform for us. We are aware that the bill for US health care has been projected to reach the trillion dollar mark and we need significant reform without a doubt.

THE LATINO POPULATION

As you know, Latinos are the fastest growing ethnic group in the country. In the next decade, Latinos will account for one in every three net additions to the US population. By 2010 the group will be the largest ethnic group in the country - estimated to become 30 million. At that time, they will represent 1 in 5 working-age persons in the country.

What do Latinos represent?

They represent youth;
motivation to succeed;
family orientation;
growing buying power;
the future of trade, manufacturing activities; and
the survival and growth of the North American hemisphere.

Indeed, we are hopeful, when health care needs of Latinos are met under national health reform, we can expect higher employment, less illness, greater productivity, and decreased health care costs.

However, Latinos, due to their position at the low income level in our society, with low levels of education and poor access to information due to the language and other barriers, have serious problems that will continue to increase and add to the costs of our health system if we continue to be ignored.

WHAT LATINOS NEED UNDER HEALTH REFORM POLICY

The following are the principles that we feel need to be addressed by health reform. We reviewed the Clinton Plan according to our list of principles and we provide recommendations that highlight our concerns.

1. Universal access for all residents, including illegal undocumented persons in the United States and its territories;
2. Guaranteed Benefits targeted at unique needs of Latinos;
3. Latino participation in policy-making;
4. A national system flexible enough to be responsive to the distinctive conditions in each of the states and territories;
5. Federal entitlements for underserved areas - for providers, for services, for network development, for academic medical education and Latino research;
6. Data collection/monitoring and accountability including information on ethnicity - an in the case of Latinos - this should be based on country of origin; and lastly,
7. Increased Latino physicians and health providers.

REVIEW OF THE HEALTH SECURITY ACT

The following is a review of the President's Plan in terms of our principles.

UNIVERSAL ACCESS

White House should develop the networks, databases now to provide universal access to health care. Based on the recent NAFTA experience, the Administration and Congress, in general, have demonstrated their support for the expansion of American programs for Latinos south of the border. We look forward to the development of networks between government and ethnic communities in the United States in the implementation of an improved health system.

An estimated 3.2 million undocumented immigrants live in the U.S. and contribute positively to the economy. Strategies for health delivery for the undocumented must be addressed and will be addressed in this hearing by my colleague from National Council of La Raza. This recommendation does not imply disregard to current immigration laws.

More than 3.5 million Americans live in the Commonwealth of Puerto Rico and should have the right to participate fully in a national health care program. Unfortunately, the Clinton health care bill continues the policy of limiting matching federal health care with less federal money than any state.

Sec. 1203 Provides health alliances with funds for appropriate extra services (outreach, enabling services). However, we feel, there should be a mandate for these services in low income areas.

Sec. 1325. Consumer information shall be made available by the alliances -should be in the language of the area and should include the information on discounts for eligible families.

Sec. 1011 Definition of family should be expanded to include common law married couples and extended family members living in a single household.

Sec. 1371 Reduction in cost sharing for low-income families

There is a limitation whereby no reduction will be available if the alliance determines that there are sufficient low-cost or combination cost sharing plans to enroll families. This limitation should be dropped since alliances will not have data on the family income to predetermine the number of families requesting discounts.

Sec. 1472 Application Process for this Family Discount...should be monitored by the state so that Alliances do not get away with limiting the discounts.

Sec. 1404 Marketing by health plans. In order to market to the Latino community certain cultural and socioeconomic information become important such as, but not limited to:

- *ethnicity of providers
- *family discounts
- *quality of care in terms of cultural competency
- *use and costs of out of network providers and services (including Emergency Rooms and Community Clinics)

Sec. 1581. Certification of Essential Community Providers - by HRSA as it is currently done...This process must identify the ethnicity of the providers for future planning. Also, the states should not have to duplicate this process, as some currently do. All funding to underserved should be from the federal directly to the local providers, clinics, hospitals that are certified. However, it becomes important to have a maintenance of effort for the dollars being spent by the states to these same clinics.

Another concern is the local management of the health plans. There should be a requirement for community health assessment - monitored by the states so that plans are held accountable to the communities they serve.

BENEFITS

We support the special services in the Plan for underserved communities - transportation, etc. There should also be case management and coordination of services by clinics/networks in comprehensive outpatient centers.

Specific health promotion in the areas targeting the Latino community become important. More funds should be made to states based on the needs of their population. In the case of Latinos, child and adolescent health, women's health, diabetes, HIV, cancer, substance abuse, depression, violence, and accidents must be highlighted for health prevention benefits.

Women's health benefits are particularly important since Latinas have such a high fertility rate and are the least likely to receive early prenatal care as a group in our country. In addition, women are the highest users with the health system and should be educated to decrease their health risks and in order to reach their families.

GOVERNANCE

Latino participation in policy-making is critical for the inclusion of the concerns unique to our group. The participation must be at all levels - local, state, and national.

We also recommend that local consumer organizations and leaders of national and regional organizations (not necessarily health) be consulted for nominations for all boards.

STATE FLEXIBILITY TO BE RESPONSIVE TO STATE NEEDS

A national system should be flexible enough to be responsive to the distinctive conditions in each of the states and territories.

For example, the population along the US-Mexico border is estimated to approach 10 million this year. The Texas border area includes some of the poorest counties in the US. Due to lenient zoning laws, over 600 colonies (unincorporated areas) exist without septic tanks, sewer systems, or running water. There is only one public hospital (El Paso) along the entire Texas border. Cross border health utilization is another reality our society ignores. We recommend that there be a US-Mexico bi-national border entity established in the Plan. You should create special funding for the area, create legislation that addresses the liability for caring for these patients, and medical training programs expanded in these areas.

Latinos are also a large part of the migrant population in this country living in rural areas with special needs. We recognize the importance of providing incentives for providers and the development of education for the people in these areas.

LATINO COMMUNITY FINANCIAL SUPPORT

The Plan addresses the need for federal support for underserved areas for outreach, for health education, for academic medical education and research.

Sec.3311 Public Health Initiatives Fund should have Latino community special initiatives to business to assist with the education of the public.

Sec.3312.8 Grants to states for community public health coalitions - will never work if the funding doesn't go to the local level -to clinics and networks which can become more comprehensive centers.

Sec.3331 Grants for health promotion will be targeted at vulnerable populations and will examine links with potential community based remedial actions. Sec.3332 however needs to be expanded to projects that serve the health needs of those outside of health plans and health alliances. The people that remain without access will need to be studied to find strategies to bring them into the health system.

Sec.3424 Limited Ability to Speak English Language program - should be expanded to include funds for specific services for health delivery networks, plans, clinics.

FUNDING FOR COMMUNITY-BASED HEALTH FACILITIES AND NETWORKS OF PHYSICIANS

It is critical for health reform to be effective in the underserved community to be directed by providers from these communities.

If you think in terms of physician productivity this becomes a statement difficult to argue. If you take the number of patients seen in one day, it makes sense that a provider fluent in Spanish will be able to see many more patients than a non-Spanish speaking provider in a Spanish-speaking neighborhood. In addition, the doctor working in an HMO can become complacent and see the minimum number of patients per day required compared to a community doctor who is dedicated to his/her business survival to be able to offer care to his/her community..

We need to develop and expand clinics and hospitals in our communities, but, we need much more dollars and technical assistance than what is provided in the Clinton Plan. In fact, the Plan calls for dissolving disproportionate care dollars to hospitals -

this is critical for our community hospitals. We must have funds for the facilities that must provide care to so many indigent and undocumented. In addition, dissolving federal funds will mean state funds disappearing unless there is clear policy for maintenance of effort in the Plan - especially for poor areas.

Sec.3421 provides grants and contracts for development of plans and networks that provide the guaranteed benefits. The problem is that we lack the range of providers who would work in these community based networks necessary to provide all the benefits.

The other major flaw in the Clinton Plan is the use of Health Professional Shortage Area (HPSA) to define underserved areas since, once we attract the doctors to these areas there is no longer a HPSA. Thus, we no longer have the ability to retain the doctors and the same poor high risk people live without health care.

The Plan has no provision to educate physicians -especially those who work in underserved areas. Physicians need information about trends in national and local health care, survival in a managed care environment. This would lead to more involvement of physicians in local health systems.

Information systems infrastructure

(Sec 3132) Access to academic centers should be expanded to urban underserved areas.

Title III Subtitle E Part 1:Health Services for Medically Underserved. Grants to community/migrant health centers should be expanded - because we all know the problems with estimating the people who these clinics serve.

Part 2: Access Initiatives

Grants, contracts, and loan programs are critical to the low-income community providers. But they should be long term with low interest.

Sec.3635 Grants to Educational Agencies. School based clinics should be linked with community physicians and clinics and health plans as a priority. Will the school clinics also be certified as ECPs and receive their own funds? A more logical way to fund them would be through health facilities outside the school systems - which will avoid another layer of bureaucracy to be involved with decision-making about the health services at a school.

TitleI Sec. 1329.Underserved Area additional authorities of alliances include offering financial incentives including payment adjustments to plans. Seed money to encourage physicians in these communities to develop new plans is also offered. However, our providers will need long-term low interest loans, not just seed money to exist in low income areas.

Title VII Sec.7113. ---

Sec.7801 Primary Care Provider Tax Credits are incredibly low and ineffective. Latino physicians in underserved areas should be allotted a proportionate tax credit based on the writeoff and disallowances made by government plans (Medicare/Medicaid). The tax credit should be increased to \$5,000 to serve as an incentive.

Sec. 7802 Expensing of equipment will be changed for the medical business.

Regional Variations of Practice Patterns. Data exists that Latinos are a relatively healthy population and the natural outcome would be to decrease the capitation base for them compared to other communities. Providers would be adversely affected and provide decreased services in areas that lack facilities, services, and providers.

SYSTEM-WIDE LATINO HEALTH DATA AND ACCOUNTABILITY

Data collection for Latinos is very new in this country's databases. The census first used Spanish origin identifier in 1970. In 1981 the Hispanic Health and Nutrition Survey collected data. In 1987 the National Medical Expenditure Survey began to oversample Hispanics. In 1989 the national model birth and death certificates began to include a Hispanic identifier with specificity for sub-groups. The Healthy People 2000 Objectives only have 25 Hispanic objectives due to lack of data baselines. In 1990, JAMA published its first issue about Hispanic Health.

Thus, we need to expand our knowledge base about Latino health. Of utmost importance, data collection should have ethnic identifiers - and for Latinos, these should be based on the country of origin.

Sec.3202 Research on health care reform (such topics as risk adjustment methods, factors influencing access for underserved groups, the impact of reform on delivery systems) should be targeted in underserved communities and be done with consultation of community providers in partnership with academic experts. Otherwise, the goals of reform will not reach these areas.

We must take Latino research seriously. "Public Health Reports" (Oct. 1993) discussed the development of a Hispanic research agenda and concluded that there was such a lack of Hispanic research that "special funding programs must be developed by the federal government to fund research on the factors such as acculturation, national origin, socioeconomic status, and migrational history on the health status of Hispanics. Research should focus on the needs of the Latino community - child and adolescent health, women's health, diabetes, HIV, cancer, substance abuse, depression, violence, and accidents."

Sec 3202 Moreover, clinical practice guidelines should be created for the community

clinic system - not just for the mainstream HMO.

Accountability for the whole system must be improved. In our communities we will continue to see providers outside the mainstream- because there is such a cash demand and a high level of undocumented. Our health delivery will not be subject to monitoring until physicians are monitored. Currently, in California, we only monitor hospitals, clinics, and nursing homes. What about IPAs, HMOs, Medical Groups?

THE NEED FOR LATINO HEALTH PROVIDERS

Sec.3001 National Council on GME - should have Latino representation.

Sec.3012 Authorization of number of resident positions will be done according to the need for the specialty nationally. However, certain communities need these doctors. The workforce planning should be done at the state level based on mandatory manpower planning. Sec.3032.C.2: Consumer advisors to the process should be from underserved communities.

Sec.3013.C.2 Underrepresentation of minority groups will be a consideration for allocation for a residency program. This was recently started as a funding priority for Title VII Primary care programs...but should be monitored by mandate for an impact. Minorities still remain at dismally low numbers in the profession.

Underrepresented Hispanics should include all Hispanics in the United States - not just Mexican American and mainland Puerto Rican.

Sec.3062 Secretary DHHS Programs. The Clinton Plan calls for expanding minority health student recruitment, retention and financial aid programs. Currently, the number of Latino physicians remains at 5% and the pipeline - the medical students and residents' numbers have remained at a plateau since 1975 - despite the federal government programs for minority science and medical career recruitment in HRSA, NIH, etc. SCIENCE Magazine, Oct. 1992, reported on the problems inherent in these programs - lack of evaluation and accountability.

There should be coordination and annual monitoring of all federal minority recruitment programs for the sciences and medicine from the DHHS Secretary Office. NIH, for example, currently runs a minority science program with sites conspicuously absent (except for 1 new program) from the Southwest - despite the fact that Mexican Americans are 63% of the Hispanic population.

There should be increased funds targeted at elementary and secondary education for math and science and mentorships.

The Plan calls for minority faculty development that should target faculty in community based clinics that are linked to the medical schools. Minority researchers are needed, but a retention mechanism for the underserved communities can be the creation of a faculty workforce in these areas. In addition, medical students and residents will have them as role models - not just hospital based faculty. There should be increased teaching clinic funds available through the NHSC.

There should be partnerships with the private HMOs and Insurance Companies to raise the funds available for medical education and minority recruitment programs, nationally. The Clinton Plan only addresses taxing health plans for GME.

Hispanic Centers of Excellence need to be enhanced as centers to develop the research and faculty for medical education. These programs were absent from the Clinton Plan.

Sec.3064 NIH Workforce Development should discuss the curriculum needs of a culturally sensitive and competent workforce - including requiring language other than english proficiency in certain geographic areas. We recognize the importance of education for all providers about various groups of patients.

BEYOND THE HEALTH SECURITY ACT

INSURANCE COMPANIES RESPONSIBILITY TOWARD MINORITIES

The Health Security Act insurance reform does not address the control issues of this industry within the health system.

The Coalition expects that insurance companies traditional methods of discrimination towards minority patients will not change overnight. However, with health reform you can mandate a more equitable insurance industry and monitor the progress in decreasing the discriminatory actions.

Minority providers also feel the institutional discrimination in our health system. In the insurance bureaucracy, it is very rare for minority physicians to sit at the table and improve our health care delivery to our patients.

We need technical assistance and training programs to develop the capability of our Latino physicians to become executives in the insurance industry.

LATINO RESPONSIBILITY FOR HEALTH REFORM

Our Coalition consists of leaders in our communities - the Puerto Rican, the Mexican American, the Cuban American, the Central and the South American communities. We need to promote, market, and demand recognition and acceptance of the significant market and voting block that Latinos will become in the near future. We demand a place at the table to improve health care delivery to our communities through health reform.

STATEMENT OF ELIZABETH KING

Mr. WAXMAN. Dr. King.

Ms. KING. Good afternoon, Chairman Waxman and guests.

My name is Elizabeth King and I am pleased to have this opportunity to present the views of the National Medical Association on health care reform. The NMA represents some 17,000 African-American physicians and we are also the convener of a National Health Reform Coalition of over 100 African-American organizations and today we are also—I am also going to present some of their views.

First of all, let me introduce myself. I am a graduate of Meharry Medical College in Nashville, and Columbia University in New York City, practicing physician in New York City, and also the Medical Director of a substance abuse therapeutic community in Queens, New York. We applaud the subcommittee's focus today on groups with special needs.

I would urge you to recognize, however, that the crisis facing the African-American community warrants not just special, but priority attention, since a reported 75,000 unnecessary deaths occur in the African-American community annually.

Another crisis is less well-known. At the turn of the century, there were 200 hospitals owned and operated by African-Americans; now, there are 10. A decade ago, there were 40 black-owned HMO's; now there are 7. Daily, our members report that they are losing their patients to large managed care organizations, to which they are denied access. So when we look at health care reform, the NMA is concerned not only about the barriers to good patient care, but also barriers to access of African-American health providers to full participation in a reformed system.

These barriers are listed in our written testimony, but in the short time that I have, I would like to highlight the concerns and recommendations that relate to these major obstacles as perceived by the NMA:

The first barrier is, and has been for years, racial discrimination. We endorse several provisions in H.R. 3600. One is the provision that Federal payments to alliances as Federal financial assistance so that civil rights protections apply.

On page 3 of our written testimony, we list specific recommendations for improvements. Related to this, the NMA would urge racial and ethnic representation in all decision-making bodies, from the National Health Board to the local health plans.

Also, regarding representation, the NMA strongly disagrees with exclusion of providers from the health alliance boards. We are not the enemy here. If someone is not present to support the patient's medical needs, we fear that bottom-line financial considerations will dominate and prevail throughout the system.

We are also concerned with the issue of State flexibility. States have too much flexibility in President Clinton's plan. The national board should set health plan standards and should mandate the drawing of boundaries without a discriminatory effect.

The NMA is pleased with the bill's provision on essential community providers, but we feel strongly that physicians and other providers who care for the underserved should be eligible for automatic certification. And we also seriously question the 5-year pe-

riod of protected status for these entities and we think it should be at least 10 years.

A major issue for the NMA is the serious underrepresentation of African-American physicians in the country, now only 3.4 percent of all physicians. To address this situation, we urge adoption of affirmative action goals and timetables to increase representation, both in primary care and in all other specialties.

We also urge the Congress to acknowledge the critically important role black medical schools like my alma mater have played in producing health professionals. H.R. 3600 is silent on these recommendations. The NMA believes that it is in the Nation's interest to preserve a mix of large, small, and minority health care businesses.

In the late 1960's when Congress first addressed the role of minority business enterprise as a policy issue, a national commitment was made to set-asides, through which a share of Federal contracts could be assured. We need similar provisions today to increase the participation of minority enterprises at every level of health care delivery.

At the same time, particularly given the current competitive climate, we need a program to build or enhance the capacity of African-Americans and other underrepresented minorities to participate in the system. A national demonstration to develop models as proposed in President Clinton's health plans, to access a program of flexible grants, contracts and loans, should also connect and integrate community-based providers, African-American medical schools, and other minority business enterprises.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you very much, Dr. King.

[The prepared statement of Ms. King follows:]

STATEMENT OF ELIZABETH KING

Good afternoon, Chairman Waxman and members of the Subcommittee. My name is Elizabeth King and I am pleased to have this opportunity to speak with you on behalf of the National Medical Association (NMA). NMA represents over 16,000 African American physicians in the United States, Puerto Rico and the Virgin Islands and next year we will celebrate 100 years of service and advocacy on behalf of minority and economically disadvantaged patients. NMA is also the co-convenor of a national coalition of over 100 health-related, civil rights, church and other community organizations, the Summit '93 Health Coalition.

Let me introduce myself as well. In addition to my service as a member of the NMA Board of Trustees, I have been the for the past 18 years the medical director of a substance abuse treatment facility in New York. Other positions I have held include fifteen years with the New York City Health Department and many years of service as medical director of a community-based health facility. I am a practicing physician and a graduate of Meharry Medical College. I received my Masters in Public Health from Columbia University.

We are most appreciative of this Subcommittee's focus on the impact of health care reform on groups with special needs. We are aware of your long standing legislative commitment to help people who are in need of essential medical care. I would urge you however to recognize that the health crisis facing the African American community warrants not just "special" but priority attention. The statistics we have attached to our testimony document the extent of that crisis. But there is also another crisis in the black community that may not be so well known. Both have implications for health care reform.

At the turn of the century there were 200 hospitals owned and operated by African Americans; now there are ten. A decade ago, there were 40 black owned HMOs; today there are seven. Our medical schools are losing ground. Daily our members report that they are losing their patients to managed care organizations to which they are denied access.

When we look at health care reform, therefore, we must look at more than barriers to patient care. We are also concerned about the access of African American health providers to full participation in a reformed system. My comments today will address barriers that both consumers and providers face. Our recommendations describe ways these barriers can be overcome.

In the interest of time, I will focus on selected barriers now and I will share our assessment of the Health Security Act in regard to them. These barriers are:

- Institutionalized racial discrimination;
- Low social and economic status;
- Inadequate numbers of providers who are culturally representative and

sensitive to patient needs;

- Insufficient access to services in underrepresented minority communities;
- Lack of knowledge of health promotion/disease prevention treatment options;
- Declining entrepreneurship opportunities; and
- Limited access to capital.

Anti-Discrimination Protection

There are a number of anti-discrimination provisions in the Health Security Act which NMA strongly endorses. For example:

- States are prohibited from discriminating on the basis of race, age, language, religion, national origin, socio-economic status, disability, or perceived health status in establishing boundaries for health alliances.
- Alliances may not discriminate against health plans on the basis of race, gender, ethnicity, religion, or mix of health professionals.
- Federal payments to alliances will be treated as federal financial assistance, so section 504 of the Rehabilitation Act, the Age Discrimination Act and Title VI of the Civil Rights Act apply to them.

These provisions are important safeguards and must remain in the bill. There are several areas however where there could be more protection. For example:

- Race-specific data collection has proved to be an effective tool for proving discriminatory patterns of care. It should be required.
- The bill should apply a discriminatory "effects" test to actions by the National Health Board, states or health alliances.
- We are opposed to provisions that allow the use of "business necessity" as a defense against discrimination complaints brought against health plans.

Enhanced Role of African Americans and Other Underserved Groups in Decision-Making

As proposed in H.R. 3600, there are significant gatekeepers at every level who will make important health care decisions. There is the National Health Board, decision-makers at State level, health alliance boards, owners/operators of health plans and at least twelve national boards, councils and committees.

NMA is in favor of requirements for consumer representatives on health alliance boards, who will serve together with employer representatives. We disagree however with the position reflected in the Health Security Act that provider representation represents a conflict of interest. Physicians are not the enemy here. We are concerned that, in the absence of a strong voice in support of patients' medical needs, "bottom line" considerations will dominate decision-making. There are physicians who could serve effectively and objectively at that level.

It is also our position that standards for representation on these various bodies should be promulgated that will result in consumer participation and racial and ethnic diversity "broadly representative of the population of the United States". This is language applicable to the National Quality Management Council in H.R. 3600 and should be required across the board. We believe that the resulting cross-section of views would be a major asset to the decision-making process.

Less State Discretion

NMA supports the creation of a National Health Board that is representative and accountable to the nation's citizens. We believe its role as envisioned in the Health Security Act should be strengthened, with appropriate safeguards so that it will function better than the current Medicaid system. At present, the Board has no authority to set minimum performance requirements that must be satisfied by health plans. It must have that authority.

Under provisions of the Administration's bill, states would have unlimited discretion to set these standards for health plans. The record of states in regulating their own Medicaid managed care plans is not encouraging. The responsiveness of states to civil and human rights issues as documented by the experience of African Americans is even less encouraging.

States also have options to give health plans special risk adjustments or other incentives to serve disadvantaged populations but are not required to do so. We believe that states should

be required to do so. We also believe that states should be required to show "measured improvements" in access and improved health status of state participants as a condition for National Board approval of their reformed systems and for continued receipt of Federal funds.

One area of state flexibility gives NMA particular concern. The bill directs states to draw alliance boundaries so as to assure "adequate market share to negotiate effectively". We strongly believe to assure fairness, boundaries should be drawn so that income and expenses of all alliances within the states will be balanced. Otherwise, we can foresee (and are already experiencing) opposition from the affluent who want to reduce health costs in their areas, while higher costs will be borne by those who can least afford them. To address this scenario, alliance boundaries with discriminatory effects must be prohibited. We believe that the withholding of federal funds would be an effective sanction to ensure compliance.

More Equitable Participation of Low Income Consumers

According to a recent poll, fifty-two percent (52%) of NMA members practice in underserved areas. A substantial percentage of their patients are Medicaid recipients. Fourteen percent of those surveyed reported that up to 50% of their patients were uninsured. Our concern for the health status of the poor and uninsured in the new system is therefore grounded in practical experience.

Health alliances as proposed in the Health Security Act are the principal means by which "blended rates" can be achieved, that is the combining of Medicaid expenditures and private premium payments so that health plans would receive the same basic amount for each participant. NMA has stated its preference for a single payer system through which equitable payments could be made; we recognize however the value of the alliance in this regard.

We also support the bill's provisions that permit Medicaid benefits to continue in effect for AFDC and SSI recipients. Yet we are concerned about those individuals who do not receive cash assistance (AFDC and SSI) and may be "priced out" of care because of mandated co-payments. We have addressed these issues in previous testimony, but would like to reiterate our recommendation that the same level of support provided to AFDC and SSI recipients (with improvements) should also be provided to poor people who do not receive cash assistance. A sliding scale for premiums and co-payments could be instituted, moreover, but it should not be instituted at levels below the poverty level. Let's not exchange one two-tier system for another.

One related issue that will have serious impact on physicians who serve the economically

disadvantaged is the denial of access by persons of low income to non-network providers. We think co-payments for these consumers who choose to go (or must go to find appropriate medical care) should be greatly reduced so that freedom of choice is an option for all.

Essential Community Providers (ECPs)

NMA is pleased with the recognition in the Health Security Act of the important role existing providers of care play in maintaining a kind of "safety net" for many health care consumers. We also support the requirement that these providers be given opportunities to enter into contractual agreements with health plans, although there are obviously details to be addressed regarding levels of compensation and utilization bills.

We do not agree with the bill's current provision that health professionals who meet the criteria specified under Section 1583 (b)(1) should not be automatically certified as essential community providers. We believe the distinctions between those who must be certified by the Secretary and those automatically certified are artificial, and they place physicians and other health professionals at an unnecessary disadvantage.

We also question the short duration of the protected status of the essential community providers. The five year period suggests that these are non-essential temporary arrangements, not components of the community's permanent health infrastructure. Alternatively, we propose a minimum ten year time frame, with the desired objective that at the end of the period they will be fully integrated and leveraged in the system. We also urge that funds provided for the support and strengthening of ECPs, as well as other mechanisms designed to meet the needs of the underserved (e.g., community health plans and community practice networks), should be allocated from a reliable source of funding that is not necessarily tied to the appropriations process.

Increasing the Supply of Underrepresented Physicians

It is commendable that the Health Security Act recognizes and addresses the need for an increase in the supply of physicians, and seeks greater representation from those groups that are currently underrepresented.

At current levels, African Americans are seriously underrepresented among physicians (3.4%), a fact with many implications. With racism and cultural insensitivity still facts of American life, continuing shortages may mean that many persons of color will simply not

seek care or will not be sought by remote managed care organizations. Further, African American physicians are frequently among the few remaining examples of educated, self-employed achievers encountered in inner city communities. The same is true for other communities where success stories may be few and far between.

We propose a more proactive approach than is currently envisioned. Affirmative action goals and timetables are needed to increase the representation of underrepresented minorities both in primary care and in all other specialties. Currently, of the almost 60,000 medical school students in this nation, only a little more than 4,000 are African American. Approved physician training programs should reflect these priorities, not just as "factors considered" (as in 3013[c]) but as mandatory recruitment, screening and selection factors. We also urge the Congress to acknowledge the critically important role that historically black colleges and universities have played over many decades in producing African American health professionals. We should make every effort to safeguard their future through targeted funding and expanded responsibilities in the reformed health care environment.

Preservation and Expansion of Minority Health Entrepreneurship

There will be an increased number of African American and other underrepresented minority physicians in the future if today's physicians are able to survive to play a meaningful role in the reformed system. At present, that scenario is in doubt.

The playing field has changed. Larger and larger health care corporations are positioning themselves for buyouts and takeovers. African American entrepreneurs have historically had difficulty in raising capital, particularly at a time when profit margins are lower and patients are being lost to managed care entities. Banks are unresponsive and individual practitioners find it difficult to keep pace with rapidly changing events.

The National Medical Association believes that it is in the nation's interest to preserve a mix of small and large health care business entities, whether they are provider networks, pharmacies, testing laboratories, etc. We also believe that it is in the nation's interest to have minority physicians and other health professionals thrive and prosper in a reformed environment, operating as owners, decision-makers, and care providers at every level.

NMA proposes a two-fold strategy to bring about these outcomes.

We call for the inclusion of set-aside provisions, consistent with precedents established by the Small Business Administration's Section 8(a) program and by PL 99-661, Section 1207, the Department of Defense 5% Contracting Goals.

These provisions will mandate the use of minority and other small business entities at every level of health care delivery — health plan, health alliance, State and National Board, etc. Enactment of such provisions will create a hospitable policy climate that will help to create an expanded level of demand.

The second aspect of our proposal on entrepreneurship calls for the incorporation within health reform legislation of a substantial grant and/or contract program for capacity building among underrepresented minorities. We envision a program that expands upon the provisions for essential community providers and community practice networks which are in the bill. We propose a national demonstration effort through which model health delivery structures can be developed. They would connect and integrate community-based organizations, historically black colleges and universities, provider networks and other minority business enterprises as models for replication and expansion. We propose further that sufficient funds be authorized and appropriated to support such models across the nation, in communities of various sizes and descriptions.

Health care is an over \$900 billion market. We must find ways to leverage some of these dollars to foster health, renew hope and provide African Americans and other underserved minorities with opportunities for employment, ownership and institution building.

It is NMA's position that these community-based integrated delivery systems can be cost effective mechanisms to address the barriers I discussed at the beginning of my testimony.

We would like to meet with the Subcommittee's members to describe these and other proposals in greater detail. Again, we thank you for this opportunity to share a vision of a reformed health care system that will truly benefit us all.

ATTACHMENT - NATIONAL MEDICAL ASSOCIATION
 SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
 U.S. HOUSE OF REPRESENTATIVES
 JANUARY 24, 1994

Health Care Issues Facing African Americans Today

African Americans make up 12 percent of the United States population, thereby constituting the nation's largest minority group. African Americans live in all regions of the country and are represented in every socioeconomic group. One-third of African Americans live in poverty, a rate three times that of the white population. Over half live in central cities, in areas often typified by poverty, poor schools, crowded housing, unemployment, exposure to a culture of street violence, and generally high levels of stress. Life expectancy for African Americans has lagged behind that for the total population throughout this century; since the mid-1980s the gap has actually widened, with life expectancy rising to 75 years for the overall population while falling to 69.6 - a gap of over 5 years. The leading causes of death for African Americans are the same as those for the majority population. However, African American men die from strokes at almost twice the rate of men in the total population, and their risk of nonfatal stroke is also higher. In the mid 1980s, according to a report by the Secretary of Health and Human Services, almost 75,000 more deaths per year among African Americans were reported than would ordinarily be expected.

Cancer

African American men also experience a higher risk of cancer than non African American men, with a 25 percent higher risk of all cancers and a 45 percent higher incidence of lung cancer. Only 38 percent of African Americans with cancer survive 5 years after diagnosis, compared to 50 percent of whites.

Diabetes

Diabetes is 33 percent more common among African Americans than whites. The highest rates are among African American women, especially those who are overweight. The complications of diabetes--heart disease, stroke, kidney failure and blindness--all are more prevalent among African Americans with diabetes than whites with diabetes.

Infant Mortality

African American babies are twice as likely as white babies to die before their first birthday. High rates of low birth weight among African American babies account for many of these deaths, but even average weight African American babies have a greater risk of death. African American infant mortality rates are higher not only for babies in their first month of life, but also for those between 1 month and 1 year of age. The major killer in this period is sudden infant death syndrome (SIDS). Other causes of death that are more prevalent for African American infants than for the total population include respiratory distress syndrome, infections, and injuries.

Violence

Homicide is the primary cause of death for African American men between the ages of 15 and 34. The homicide rate for those between ages 25 and 34 is 7 times that of whites. African Americans have a 1-in-21 lifetime chance of being murdered, and African American women are more than four times as likely to be homicide victims as white women. Most young African American murder victims are killed with firearms in the course of an argument. It is estimated that about half of all homicides in the United States are related to alcohol use and 10 percent or more to the use of illegal drugs.

AIDS

The rate of AIDS among African Americans is more than triple that of whites. Among women and children, the gaps are even wider. African American women face between 10 and 15 times the risk of AIDS as compared to white women. African American children account for more than 50 percent of all children with AIDS. The proportion of AIDS cases associated with intravenous drug transmission abuse is greater for African Americans than for other AIDS victims, and higher rates of heterosexual transmission of the HIV virus and transmission of the virus from mother to infant occur as a consequence.

Hypertension

Disparities in the experience of health risks mirror some of the most striking disparities in health outcomes. High blood pressure is much more common among African Americans of both genders than among the total population. Severe high blood pressure is present 4 times more often among African American men than among white men. Obesity is a problem for 44 percent of African American women aged 20 and older, compared to 38 percent for low income women and 27 percent for all women. Poor nutrition, smoking, alcohol and drug abuse, and other risk factors appear more commonly among minority and other low income populations.

Teenage Pregnancy

Adolescent pregnancy is a major concern among the African American population, for its social and economic consequences as much for its health effects. There are higher incidences of infant mortality and morbidity, especially for very young pregnant girls. But even greater risks indirectly threaten the health of both mother and baby because of the patterns of poverty and low educational attainment that often become solidified as a result of early childbearing. Actual rates of childbirth among African American teenagers have dropped since the 1960s, but because the number of girls in this population has risen 20 percent, the total number of births has increased. In 1987, births among girls aged 15 through 17 were 3 times as likely among African American girls as among white girls. Birth rates among African American girls younger than 15 were nearly 5 times higher, than the rate for white girls.

Summary

Statistics demonstrate that African Americans receive limited early, routine and preventive health care. Early prenatal care can reduce low birth weight and prevent infant deaths. Early detection of cancers can increase survival rates. Appropriate medical care can reduce the frequency and severity of the complications of diabetes, which African Americans experience at higher rates than others. Information about actual use of health care services confirm these indications. African Americans make fewer annual visits to physicians than whites, and African American mothers are twice as likely as white mothers to receive no prenatal health care or prenatal care only in the last trimester of their pregnancies. Hospital emergency rooms and clinics are a much more common source of medical care for African Americans than for whites, and 20 percent of African Americans compared to 13 percent of whites report no usual source of medical care. Though recent statistics are not available to assess immunization coverage by race, children in central cities—many of whom are African American—lagged as much as 20 percent behind immunization rates for children living in other places.

Mr. WAXMAN. Ms. Guillermo.

STATEMENT OF TESSIE GUILLERMO

Ms. GUILLERMO. Thank you, Mr. Chairman and guests.

My name is Tessie Guillermo and I am the Executive Director of the Asian and Pacific Islander Health Forum, a national nonprofit health advocacy organization based in San Francisco, Calif.

I would like to say first that it should come as no surprise that my remarks will mirror very much the remarks of my preceding witnesses, because communities of color I think suffer from the same types of access problems together.

In September of 1993, the Health Forum announced its support for President Clinton's Health Security Act. We believed that the plan outlines a system that provides for a major advancement in addressing inequities in the U.S. health care delivery system. Our support, however, was qualified, in that we identified a number of areas of concern to Asian and Pacific Islander communities not adequately addressed in either the draft plan nor the bill as introduced to Congress.

Chief among these areas are questions of universal access, health professions development, long-term security for community-based services and quality management measures. With regard to universal access, very little information exists to determine levels of disadvantage and underservice for the 7.4 million Asian and Pacific Islanders that reside in the United States. However, national data indicate that A/PI's nationwide are 21 percent uninsured and have the lowest average physician utilization rates.

While H.R. 3600 does address the financial barriers that will close the uninsured and underinsured gap to a degree, many health care providers understand that there are other barriers which act to deny health care to Asian and Pacific Islanders, even for those who have health insurance coverage.

These nonfinancial barriers to care, such as education, geographic location, race, ethnicity, language and medical condition, are recognized in the President's plan, and language that prohibits discrimination based on some of the above factors is contained throughout the plan. While we are pleased that the antidiscrimination language exists, H.R. 3600 fails to include mention of title VI of the Civil Rights Act, the most powerful mechanism that currently exists in law to assure that antidiscrimination protections for the individual enrollee are in place with regard to government subsidized services. It is essential that specific standards be implemented pursuant to title VI for measuring and monitoring access of the underserved be established and implemented.

More than two-thirds of Asian and Pacific Islander Americans are immigrants to the United States. In 1990, census data indicate that more than one-third do not speak English very well. These characteristics act as barriers in accessing the current health care delivery system because of the associated language, race, ethnicity and cultural differences with mainstream medicine. However, only in titles E and F—only in subtitles E and F of title III are specific authorizations made to address these barriers and then only by qualified community health practice groups who must compete for funding.

We are concerned that there may be a perception by other qualified health plans within an alliance that they will not be subject to the same requirements to assure access to vulnerable underserved populations, unless they wish to qualify for title III funds. Further, there exists no financial incentives to guarantee access to such disadvantaged individuals outside of title III, except with regard to States' options to risk adjust premiums for disadvantaged populations at their sole discretion.

The requirement to provide access to disadvantaged populations must not be perceived as a financing option as in title I, nor should targeted resources be discretionary, as in title III, and subject to an annual appropriations process. With regard specifically to native Hawaiians, we are troubled that H.R. 3600 makes no mention of protecting or enhancing the Native Hawaiian Health Care Centers, established by the Native Hawaiian Health Care Act.

While the centers do not provide comprehensive primary care, they are often a major bridge to the larger health care delivery system, as well as to many other essential services in Hawaii where access is not available to small, rural, and underserved Hawaiian communities. We would like to see that the United States recognizes that special obligation to the Hawaiian people by preserving and enhancing the role of the Native Hawaiian Health Centers.

We would also like to see universal access coverage be expanded to the U.S. trust territories in the Pacific. Although there is a perception that Asians are overrepresented in the health professions, the reality is that there is maldistribution both ethnically and geographically. Smaller and newer A/PI ethnic groups are disproportionately underrepresented in the health fields, and the majority of Asian and Pacific Islander physicians practice in the Northeast and North Central United States, while 60 percent of Asian and Pacific Islanders reside in the West.

For both physicians and nurses, the aggregation of all Asian and Pacific Islanders into a single ethnic category for purposes of determining representation in their respective professions masks the disparity that exists within specific ethnic groups and undermines the intent to provide an adequate supply of health professionals to all disadvantaged minorities. Title III programs for training and retraining of health professionals which targets funding for disadvantaged persons and underrepresented minorities may not be available to Asian and Pacific Islander health professionals if the conventional method of defining Asian and Pacific Islander communities is in the aggregate.

Section 1582 of Title I lists automatically certified classifications for essential community providers. Because language and cultural issues are among the most persistent access barriers nationwide, the automatic certification of providers who provide linguistic and culturally competent services based on standards developed by the Secretary should be included in this section.

[The prepared statement of Ms. Guillermo follows:]

STATEMENT OF TESSIE GUILLERMO

Thank you, Mr. Chairman and members of the subcommittee. My name is Tessie Guillermo and I am the Executive Director of the Asian and Pacific Islander American Health Forum, a national, non-profit health advocacy organization based in San Francisco, California. The Health Forum has dedicated itself to promoting policy, program and community based research efforts for the improvement of health status of Asian and Pacific Islander Americans (A/PI).

In September of 1993, the Health Forum announced its support for President Clinton's Health Security Act. We believe that the plan outlines a system that provides for a major advancement in addressing inequities in the U.S. health care delivery system. Our support, however, was qualified in that we identified a number of areas of concern to A/PI communities not adequately addressed in either the draft plan, nor the bill as introduced to Congress. Chief among these areas are specific questions of universal access, health professions development, long-term security for community based services, and quality management measures as they relate to underserved segments of the A/PI community.

Universal Access

Very little information exists to determine levels of disadvantage and underservice for the 7.4 million A/PI's that reside in the United States, however national data indicate that A/PI's nationwide are 21% uninsured and have the lowest average physician utilization rates at 4.5 visits/person. While HR3600 does address the financial barriers that will close the uninsured and underinsured gap, many health care providers understand that there are other barriers which act to deny health care to Asian and Pacific Islanders, even for those who have insurance coverage. These non-financial barriers to care, such as education, geographic location, race, ethnicity and language and medical condition are recognized in the President's plan, and language that prohibits discrimination based on some of the above factors is contained throughout the plan.

While we are pleased that the anti-discrimination language exists, HR3600 fails to include mention of Title VI of the Civil Rights Act, the most powerful mechanism that currently exists in law to assure that anti-discrimination protections for the individual enrollee are in place with regards to government subsidized services. It is essential that specific standards be established, pursuant to Title VI, for measuring and monitoring access of the underserved.

More than two-thirds of A/PI Americans are immigrants to the U.S. and 1990 Census data indicate more than one-third do not speak English 'very well'. These characteristics act as barriers in accessing the current health

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House Subcommittee on Energy and the Environment

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care delivery system because of the associated language, race/ethnicity and cultural differences with mainstream medicine.

However, only in Subtitles E and F of Title III, are specific authorizations made to address these barriers and then only by qualified community health groups, who must compete annually for funding. We are concerned there may be a perception by other qualified health plans within an alliance that they will not be subject to the same requirements to assure access to vulnerable, underserved populations, unless they wish to qualify for Title III funds. Further, there exists no financial incentives to guarantee access to such disadvantaged individuals outside of Title III, except with regard states' options to risk adjust premiums for disadvantaged populations, at their sole discretion, as stated in Section 1203 of Title I.

The requirement to provide access to disadvantaged populations must not be perceived as a financing option as in Title I, nor should targeted resources be discretionary, as in Title III, and subject to an annual appropriations process. There is real danger of funding levels being insufficient in either case to adequately provide assurances of universal access.

Health Professions Development

Although there is a perception that Asians are overrepresented in the health professions, the reality is that there is maldistribution both ethnically and geographically. Smaller and newer A/PI ethnic groups such as the Vietnamese, Koreans, Hawaiians and other Pacific Islanders are disproportionately underrepresented in the health fields, and the majority of A/PI physicians practice in the northeast and northcentral U.S., while 60% of A/PI reside in the West. While only 6.5% of Asia educated physicians in the U.S. are primary care practitioners, many of the remaining 93% specialty care physicians provide primary care services to Asian and Pacific Islander Americans because of their language skills and knowledge about cultural practices regarding health. These providers therefore bridge the gap for A/PI consumers in an unresponsive health care system.

Further, the majority of the supply of Asian nurses are hospital based, vocational and registered nurses, whose jobs are in danger in a reformed and more streamlined health environment. Unless they can be identified and re-trained as mid-level practitioners, be otherwise placed to provide primary care services, the health care community will lose a valuable resource to address the language and cultural barriers faced by A/PI's in maneuvering a health care system.

For both physicians and nurses, the aggregation of all A/PI's into a single ethnic category for purposes of determining representation in their respective professions, masks the disparity

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that exists within specific ethnic groups. Title III programs for training and re-training of health professionals, which targets funding for "disadvantaged" persons and "underrepresented" minorities may not be available to A/PI health professionals if the conventional method of defining A/PI ethnic communities is in the aggregate.

Protection of Community Based Services

Community Health Centers and other traditional, community based providers of the underserved are in a strong and unique position to provide a ready point of access to A/PI vulnerable populations. The historical role and explicit mission of CHC's in particular has been to serve the underserved. Further, their role in continuing to serve ineligible individuals is critical to maintaining control of costs to the overall health care system.

Section 1582 of Title I lists automatically certified classifications for "essential community providers", eligible for reimbursement for the costs of care associated with providing services for disadvantaged or underserved populations. Because language and cultural issues are among the most persistent access barriers nation-wide, the automatic certification of providers who provide linguistic and culturally competent, based on standards developed by the Secretary, should be included in this section.

Further, notwithstanding a mandate for all health plans to abide by anti-discrimination provisions as contained in Subtitle E, Title I, minority community based providers have little negotiating power with which to protect themselves and their practices in fully integrated environment. Methods for determining payment for the cost of care for underserved populations provided by essential community providers must be realistic, consistent and developed with full information about all costs.

Quality Management Measures and Data Development

As stated previously in my testimony, data on A/PI health professionals is aggregated, and thus meaningful analysis on specific ethnic representation is not done, making it difficult to develop policies and programs appropriate to underrepresented A/PI health professionals.

Health data is often aggregated in the same manner, but most often, Asians and Pacific Islanders are coded within "non-white" or "other" categories. Given the emphasis on quality management within the Administration's plan, measures such as patient satisfaction, performance and outcomes should include A/PI ethnic identification, consistent with U.S. Census ethnic categories, in data collection, analysis and reporting.

Mr. WAXMAN. I wanted to ask you about that, if I might?

Maybe all three of you would want to respond to this—do you feel that community-based providers and clinics will be incorporated in the plans that will be offered to people in that community as the administration envisions, or is that a problem as you see it?

Ms. GUILLERMO. What we are observing, particularly in California, is that with some of the reforms that are going on, community-based providers of care are not being ensured inclusion into alliance plans and insurance cooperatives that are being formed to offer managed care to communities throughout the State.

Mr. WAXMAN. You said they are or are not?

Ms. GUILLERMO. They are not.

Mr. WAXMAN. They are not.

Ms. GUILLERMO. They are not. There is a—I guess a raging battle going on throughout the State of California and other States with regard to protecting community-based services and having them be equal players in the reform system.

Mr. WAXMAN. Dr. King, what has been your experience? What do you think will happen?

Ms. KING. The same thing is happening in New York. New York unfortunately already has some mega-managed care programs in the health insurance plan of greater New York and Blue Cross-Blue Shield. And they are closed panels. And the community-based physicians are having very great difficulty in access to those plans, if they were not already in. They had nothing to do with the management or the business side of the plans, but they are the workers, if they can get into the plans at all. So we already have seen that happen. And now the State medical society is trying to start their own, and you have to, of course, be a member of the State society in order to participate in their plans. So we have already got—encountered that, even though the health care reform hasn't even been, you know, started yet.

Mr. WAXMAN. That is a trend that you fear may be accelerated in the Clinton proposal?

Ms. KING. Yes.

Mr. WAXMAN. Dr. Rios.

Ms. RIOS. I would just like to add, since my colleagues have commented about the physicians as providers not being left out of the health plans, I think the community clinic specifically needs to be supported, because the community clinics of the future are going to be what we consider hospitals currently in our system.

There won't be enough money to keep acute-care tertiary hospitals in the communities. We are going to have more comprehensive clinics, that is the wave of the future. And with reform I think it is important that we build up the concept that community-comprehensive clinics can be quality-care clinics, mainstream-type clinics, that should be controlled by the community to best serve the community needs. And those clinics, I don't see them as being able to survive when the Clinton plan would like to see them just become part of an HMO.

I think they need to be considered separate because they serve such a great need in our communities. There is just too many peo-

ple that are undocumented, too many people that have no ability to get to those health plans that will be serviced by these clinics.

Mr. WAXMAN. All three of your communities have a large number of low income people. Now, the Clinton plan would envision everybody being in an alliance and then choosing among several plans, one of which would be an HMO, presumably which would be the lower, lowest-priced option, and then the highest-price option presumably would be a fee-for-service.

Do you think that in order to make this whole idea of competition work, that we ought to subsidize low-income people if they want to go to a fee-for-service plan so that they will really, genuinely have a choice?

Ms. GUILLERMO. I think particularly with regard to cultural minorities that probably won't be able to find adequate culturally competent services within a low-cost plan, because the cost of that probably has not adequately provided for the costs of providing care to that particular population. So I think that the cost of the care—the provision of services will probably be at a level that is not practical for them, so the need to have enhanced services is going to need to be subsidized, if not an individual subsidy for the enrollee.

Mr. WAXMAN. Dr. King, do you want to comment?

Ms. KING. Yes, I agree with that. The low-income community person may really opt for the fee-for-service, but if that patient can't pay for the fee-for-service, say, they don't have Medicaid or Medicare, then they should at least be given that option at a lower fee or a subsidized rate.

Mr. WAXMAN. And did you—

Ms. RIOS. Just to add, I agree with the subsidies for low income, but we need to have it mandatory. It can't be this wishy-washy, well, sure, let's offer it but then let's give the health alliances the ability to say that they can't—that they have reached a limit and we don't have any more room for more discounts to our families in our community, and then use an excuse that we have plenty of low-cost plans that may be, you know, not fair to the people, not culturally competent or whatever. So I think it should be some mandatory system set in place.

Mr. WAXMAN. Thank you.

Mr. Brown.

Mr. BROWN. I have no questions, Mr. Chairman.

Mr. WAXMAN. Well, I think the three of you have given us excellent testimony. I very much appreciate it. We will have your full testimony in the record. We are going to share that with our colleagues, go over it, and look specifically at some of the recommendations you have made.

Thank you.

Our last panel will discuss the impact of the President's plan on undocumented immigrants. Luis Estevez, is the Director of Medical Affairs for the Morrisania Diagnostic and Treatment Center of the South Bronx; Cecilia Munoz is a Senior Immigration Policy Analyst with the National Council of La Raza; Susan Drake is a Senior Attorney with the National Immigration Law Center in Los Angeles; Richard Parkins is with the Office of Migration and Refugee Services of the U.S. Catholic Conference.

I want to thank you all for being here. Your prepared statements will be in the record in their entirety.

What we would like to ask you to do is to limit your presentation to us to no more than 5 minutes.

Dr. Estevez, why don't we start with you.

STATEMENTS OF LUIS M. ESTEVEZ, DIRECTOR OF MEDICAL AFFAIRS, MORRISANIA DIAGNOSTIC AND TREATMENT CENTER, NEW YORK CITY; CECILIA MUNOZ, SENIOR IMMIGRATION POLICY ANALYST, NATIONAL COUNCIL OF LA RAZA; SUSAN B. DRAKE, SENIOR ATTORNEY, NATIONAL IMMIGRATION LAW CENTER; AND C. RICHARD PARKINS, DIRECTOR, REFUGEE AND IMMIGRATION POLICY, U.S. CATHOLIC CONFERENCE

Mr. ESTEVEZ. Good afternoon, Mr. Chairman, Members of the House, honored guests. Thank you for inviting me to testify before the Subcommittee on Health and the Environment concerning the treatment of undocumented persons under the Health Care Security Act.

My name is Dr. Luis Miguel Estevez and I am currently serving as the Director of Medical Affairs of the Morrisania Diagnostic and Treatment Service, located in the heart of the South Bronx. I am also a practicing pediatrician.

Morrisania is part of the New York City Health and Hospitals Corporation, which is the largest public hospital system in the United States. Morrisania is also the largest freestanding health center in New York City.

Throughout my testimony, I will present examples of how health care issues affect this community. These problems are not unique, however, and invariably affect most other inner-city communities. Moreover, I will present evidence that indicates that good public health policy is also sound fiscal policy.

Morrisania—the Morrisania community is characterized by its high percentage of Latinos, African-Americans and other minorities. Many of these are newly arrived and a considerable percentage are undocumented. The health status of this community is characterized by many severe and unabated chronic health problems. These include high infant mortality rates, low birth weight, high rates of asthma, elevated blood lead and cholesterol, in addition to heart disease, diabetes, hypertension, cancers of the female reproductive tract, sexually transmitted diseases, lung cancer and substance abuse.

In addition, our community is located at the epicenter of HIV endemic in New York City. These conditions are all either entirely preventable, or at a minimum, amenable to very cost-effective treatment through early detection and timely intervention.

The Health Systems Agency of New York City, HSA, has in fact quantified the extent to which early intervention in an ambulatory care center is useful in preventing more costly hospitalizations. An index called the Ambulatory Care Sensitive Index is used to track and compare hospitalization rates for 14 conditions, including many of the conditions cited previously.

The ACS Index for the Morrisania community is the highest in the borough of the Bronx, and one of the highest in New York City.

It is probably not coincidental that according to the 1990 U.S. Census, this area includes a significant number of undocumented persons.

What evidence is there for such a statement? First, while recognizing the limitations inherent in gathering statistical data on the undocumented, a similar correlation is noted in many other communities with similar profiles.

Second and most important is the way in which a person's legal status affects their health-seeking behaviors. Undocumented persons are less likely to seek preventive services and only utilize the more costly emergency room services as a last resort.

Indeed, these services become costly at a human as well as an economic cost. For the undocumented, even a small change in the system can affect health-seeking behaviors. For example, an extension clinic run by my health center recently computerized its registration process.

Many undocumented persons ceased seeking care for fear that such records would be shared with the INS. Instead, they began using the emergency room of the local hospital for all of their care.

I stated before that good public health policy can be synonymous with prudent fiscal policy, and I would like to cite some examples: First, Moore, et al., in a study published in the *American Journal of Obstetrics and Gynecology*, were able to quantify the difference in hospital costs for mother-child pair for those women receiving prenatal care and those who did not.

The difference in health care costs per pair was \$2,168, and it was so significant that they concluded that it would actually be cost effective, and indeed generate a cost savings, were prenatal care to be offered to those women free of charge.

Two, the cost of treating a person with hypertension can be as little as a few hundred dollars a year. A person suffering a stroke from uncontrolled hypertension who stays even one day in an intensive care unit, on the other hand, can generate costs well in excess of \$3,000 per day.

The same holds true for asthma and diabetes. For these conditions, it is clear that an ounce of prevention is worth many thousands of dollars for cure.

How then can we respond to these concerns while recognizing the political realities of health care legislation?

My recommendations are as follows: First, create a modified package aimed specifically at preventive health services. This package must include, at the minimum, prenatal care, immunizations and ambulatory treatment of the ACS Index conditions.

Two, since a large number of undocumented persons are employed, allow them to participate through their employer.

Third, target public health funds for those areas with high rates of tuberculosis, HIV disease, high infant mortality, low birth rate and other conditions which serve as markers of health status without regard to legal status.

Four, in general increase funding for health promotion and disease prevention activity.

And lastly, continue disproportionate share fundings to essential community health providers.

As a physician and a public servant, I honestly feel that this legislation presents us with the opportunity to positively affect the health of our Nation.

I thank you.

Mr. WAXMAN. Thank you very much for your testimony.

Ms. Munoz.

STATEMENT OF CECILIA MUNOZ

Ms. MUNOZ. Thank you, Mr. Chairman. I appreciate the opportunity to testify before the subcommittee today.

My organization's interest in the health care reform process goes well beyond the questions of coverage of different groups of immigrants, especially because Latinos are less likely to have health insurance than any other group in the United States. In keeping with the subject of today's hearing, among the most critical issues which this bill presents, which the President's bill presents, is its failure to cover undocumented immigrants, its failure to cover even all people legally in the United States, and I would differ from the representative from the administration this morning in pointing out that there are legal—people, legal residents in the United States, who are very likely here permanently, who would not be provided coverage under the President's proposal.

As I think my colleagues on the panel will be pointing out, failing to cover the undocumented threatens both the public health and the cost-containment purposes of health care reform. But I would like to focus my oral comments on the civil rights crisis which is threatened by the combination of excluding the undocumented from health care and creating a Health Security Card.

We believe this is a very serious threat to the civil rights of all Latinos, Asian and Pacific-Americans and others in the United States, even those of us who were born here.

If it is widely understood that a health care card is only available to people who are legally in the United States, the card itself becomes a vehicle for discrimination against anyone who by virtue of their ethnicity is suspected of being an immigrant. For example, if those of us seeking medical care are required to show our cards in order to receive services, some U.S. citizens and legal residents may be denied access to health care or experience significant delays if there are questions about the validity of our documents.

In practice, we believe the requirement to actually show a card may be applied exclusively to Latinos and Asians, recent immigrants or others perceived as being foreign. In addition to differential and discriminatory treatment, these same groups are likely to be scrutinized more heavily than people who their health providers perceive as looking like "Americans."

When Latinos or Asians lose our documents, we will be more likely to have difficulty in replacing them because of fear that we might present fraudulent documents in order to get a health care card. There are already laws on the books which provide a vivid example of the kind of treatment that Latinos can expect in the health care process. The law which requires that employers check the documents of everyone that they hire has already led to widespread discrimination against Latinos and Asians in the workplace.

We are not simply theorizing that this kind of discrimination will occur in the health care context. We know that will occur and we know it will occur to a vast extent. We think perhaps most gravely the Health Security Card is likely to become a de facto national ID card which only some Americans will need to carry on us at all times.

Some Members of Congress have already suggested that the Health Security Card could be used as an immigration control document. Even if the use of the card is not expanded beyond health care as the administration suggests, any card which is issued only to persons who are legally in the United States will become a card that Latinos, Asians and others suspected of being foreign by virtue of our ethnicity will have to carry all the time in order to protect ourselves from harassment from law enforcement officials and to identify ourselves for even simple procedures like opening bank accounts.

My boss, NCLR's President, Raul Yzaguirre, had to carry a card when he was growing up in Texas. This is a man whose family has lived in Texas since the 1720's. Your colleague in the House, Representative de la Garza, also carried a card. He still carries his card in his wallet. They can testify from personal experience that such a document becomes a powerful tool for discriminating against people on the basis of their ethnic experience, their surname or their speech accent.

We found again the administration's statement this morning that they would prohibit the misuse of such a card outside of the health care context not particularly comforting. It is tantamount to saying that we will create a new way to discriminate against people, but that is OK because we will provide you with a means of addressing it after it occurs. We don't find that very comforting.

President Clinton has made the Health Security Card a symbol of the good things he hopes to achieve through health reform. We believe in these good purposes but we believe the card has a much darker meaning for our community. We have communicated to the administration that it is possible to have health reform with a card which does not discriminate.

You referred to our recommendation earlier this morning when you asked your question of the administration. There are some States which in their Medicaid systems provide cards to everybody who has access to any portion of the system, and even if the administration insists on denying health care coverage to some groups of people, as we believe it should not, we still believe that you can provided provide an identical card to everybody in the United States and differentiate between different kinds of coverage by encoding that information on the magnetic strip on the back of the card.

Unless we do that, the card will, and the health care reform process itself will pose an enormous threat to the civil rights and the

dignity of the Nation's 25 million Latinos, and it puts our community in the untenable position of having to choose between supporting health care reform, which Latinos in this country very badly need, and protecting our civil rights. And that is a choice we would just as soon not be put in the position of making.

Mr. WAXMAN. Thank you very much, Ms. Munoz.

[The prepared statement of Ms. Munoz follows:]

STATEMENT OF CECILIA MUNOZ
ON IMMIGRANTS AND HEALTH CARE REFORM
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
COMMITTEE ON ENERGY AND COMMERCE
U.S. HOUSE OF REPRESENTATIVES
JANUARY 24, 1994

I. INTRODUCTION

Good afternoon, Mr. Chairman and members of the Subcommittee. I am Cecilia Muñoz, Senior Immigration Policy Analyst for the National Council of La Raza (NCLR). NCLR is the nation's largest constituency-based national Hispanic organization and is dedicated to improving life opportunities for Hispanic Americans. It serves as an umbrella organization for over 160 affiliated Hispanic community-based organizations, which provide employment, education, health, housing, immigration and social services to over two million Hispanics annually in 38 states, the District of Columbia, and Puerto Rico.

NCLR takes a keen interest in the issue of health care reform; health care costs and lack of access to health services have long represented major concerns for the Latino community. A 1992 study conducted jointly by NCLR's Health component and the Labor Council for Latin American Advancement found that Hispanics are less likely than either Whites or Blacks to have any health insurance coverage.¹ In 1990, over 6.9 million Latinos, (32.4% of the Hispanic population) were uninsured, compared with 26.9 million Whites (12.9%) and nearly 6.1 million Blacks (19.7%.) Hispanics comprised 9% of the 1990 U.S. population and over 20% of the uninsured population. In addition, Latino children are more than twice as likely to be uninsured as White children and nearly twice as likely to be uninsured as Black children.

While the focus of this panel at today's hearing is on a particular group of immigrants largely identified with the Hispanic community -- namely undocumented immigrants -- I feel obliged to point out that immigration does not explain the high representation of Latinos among the uninsured. The lack of health insurance is much more the result of Latinos' high concentration in low-wage work and therefore among the working poor. As a civil rights organization which represents the diverse constituency of Latinos in the United States, the vast majority of whom were born here, NCLR is profoundly concerned with the high cost of health care and the lack of access to care within our community. As a result, we strongly support the principal goals of the Clinton Administration's initiative on health reform, providing universal access to health care and cutting the escalating cost of medical care.

¹ *Hispanics and Health Insurance, Volume I*, Labor Council for Latin American Advancement and National Council of La Raza, March 1992.

While we share a commitment to these goals, NCLR is concerned that the legislation proposed by the Administration falls short of achieving them, especially for the nation's 25 million Latinos. NCLR's interest in the proposed legislation goes well beyond the question of coverage for immigrants;² however, among NCLR's principal concerns with the bill are its failure to provide true universal coverage, and the likelihood that the immigration restrictions combined with the Health Security Card proposed by the bill will become a vehicle for massive discrimination against all Latinos in the United States. My testimony today will focus on these two concerns.

II. UNIVERSAL COVERAGE

A. *Gaps in the Administration's Proposed Legislation*

There are several ways in which the Administration's Plan fails to realize the promise of universal coverage. First, while the Plan purports to cover all immigrants legally in the United States, the definition of what constitutes a "legal resident" is incomplete, and omits several important groups of newcomers who reside and work in the United States legally. These groups -- which include the family members of newly legalized immigrants, and persons provided protection against deportation and work authorization because of conditions in their home countries -- are both predominantly Latino, and both living and working legally in the U.S. Under the Plan, employers will be obliged to pay premiums for these workers, yet the workers themselves will be denied access to health benefits paid for by these premiums. Most of these individuals are long-term residents of the U.S., many of them have children who were born here. It is not only unnecessary and unfair to exclude these newcomers from health coverage; it is also not in the interest of the public health.

Second, The plan fails to provide a secure, self-renewing funding source for essential community providers, such as community and migrant clinics, that have been a key source of care for immigrants and other underserved populations. Immigrants not covered by the current plan, migrant workers who may not live in any state long enough to establish residence, undocumented immigrants, the homeless, and persons with developmental disabilities and mental health problems already rely on this fragile patchwork of providers; by curtailing their funding and leaving these populations with no other resource for health care, the Clinton Plan threatens to actually reduce health care which is currently available to these individuals. In addition, the limited funding proposed for these providers under the Clinton Plan will be subject to the annual appropriations process, and therefore vulnerable to further cuts or elimination.

² See, *Hispanics and Health Insurance*, op. cit.; *Hispanics and Health Insurance: Volume 2, Analysis and Policy Implications*, Labor Council for Latin American Advancement, National Council of La Raza, September, 1992.

Finally, as representatives of the Administration have stated on several occasions, the Plan explicitly bars undocumented immigrants from health care coverage. This exclusion is based on the philosophy that providing health care to the nation's three to four million undocumented immigrants³ is costly, and that denying them health coverage will eliminate a "magnet" which is drawing these migrants across the nation's borders. Closer examination of the available data on undocumented immigrants and health care suggests that both of these assumptions are false.

Consistent with the data on the use of other public benefits by immigrants (and notwithstanding the controversial and poorly documented statistics which are being used by California Governor Pete Wilson), studies on immigrants and health care show that, even immigrants who are eligible for federally-funded services use them much less than the general population. For example, despite the fact that undocumented immigrants are eligible for emergency care services funded through Medicaid, an INS study of newly legalized immigrants shows that, in the last year during which they were undocumented, only 25% of legalized immigrants' health care was paid for by the government.⁴ In contrast, 53% of all hospital care in the U.S. in the same year was government funded. In addition, 47% of legalized immigrants' hospital stays were totally or partially paid for by private insurance and 45% by self or family. Denying undocumented immigrants access to health care is likely to represent a loss in services which are available to many who are working in the United States and have employer-sponsored health insurance.

While the current political atmosphere -- in which undocumented immigrants are being blamed for everything from unemployment to pollution -- may make it politically palatable to bar them from receiving basic medical care, under close examination, denying coverage to undocumented immigrants undermines the overall objectives of health care reform and does nothing to advance the nation's immigration control agenda.

B. Excluding the Undocumented from Coverage Undercuts the Objectives of Health Reform

The Administration has correctly pointed out that universal health care coverage is in the interest of the public health in the United States. By denying access to health care to a major group of long-term residents in this country, the Clinton Plan threatens to undermine its own objectives. Simply put, diseases do not check for immigration documents when they

³ The Immigration and Naturalization Service estimates that there are 3.2 million undocumented immigrants living in the United States; estimates by the U.S. Bureau of the Census suggest that the total number is closer to four million.

⁴ *Report on the Legalized Alien Population*, U.S. Department of Justice, Immigration and Naturalization Service, 1992.

strike; leaving them untreated not only endangers the person who needs medical assistance, but endangers the community in which s/he lives. Similarly, failing to immunize the nation's estimated 300,000 undocumented children wastes all of the efforts spent immunizing all of their playmates and schoolmates.

The Clinton Administration also argues -- again correctly -- that part of the reason that the nation's medical costs are out of control is because too many uninsured people end up in the nation's emergency rooms with conditions which could have been prevented or treated early on at much less expense. Yet, any anticipated cost savings under the Clinton Plan will be threatened by leaving a major U.S. population with no alternative but to seek medical care in the only place it will be available, in the emergency room. Similarly, it is well documented that every dollar spent on prenatal care saves three dollars in the first year of a child's life; it is penny wise and pound foolish to leave pregnant women -- many of whose children will be U.S. citizens -- without prenatal care because they lack immigration status. The Administration's proposed legislation may sacrifice its own anticipated cost savings for the sake of what it believes to be politically expedient; NCLR believes that the very goals of health reform will be jeopardized as a result.

C. *Denying Health Coverage to the Undocumented Does Nothing to Control Immigration*

NCLR believes that it is appropriate for the nation to grapple with its failure to control its borders. However, it is a gross, dangerous, and unnecessary mistake to make health care policy an instrument of immigration control. First, there is little evidence to suggest that undocumented immigrants come to the United States seeking health care. While a number of media reports suggest that undocumented immigrants are coming in large numbers to the U.S. to avail themselves of free medical care, closer scrutiny shows these reports to be exaggerated. A recent report on ABC's *20/20*, for example, suggested that undocumented women come to the U.S. in order to give birth. Yet every single one of the women interviewed for the show had legal authorization to be in the United States. A report which was ostensibly about undocumented abuse of the U.S. health care system provided not a single example of an undocumented person actually abusing the system.⁵

In fact, there is evidence to suggest that, contrary to popular belief, persons living in the United States near the Mexican border are likely to cross to Mexico to receive medical care. A 1992 survey by the Families USA Foundation found that 99% of Mexican physicians surveyed have treated U.S. patients; 90% of those who went to Mexico were

⁵ ABC News *20/20*, Transcript #1203, January 17, 1992.

either U.S. citizens or permanent residents.⁶ The principal reason for U.S. citizens and residents to travel to Mexico for health care is cost; quite simply, for the uninsured, access to medical care and prescription drugs is better in Mexico than it is in the United States. This evidence directly contradicts the popular view that access to health care draws immigrants to the United States; to the extent that there is a pull, it appears to move from North to South.

Despite the popular view that undocumented immigrants are drawn to the U.S. by social services and health benefits, studies on the actual use of benefits by this population show overwhelmingly that these migrants are actually unlikely to seek government-funded services because of the fear of being discovered by the INS. A 1991 survey of undocumented women in San Francisco found, for example, that 23% of the women surveyed had children eligible for government benefits, and only 5% actually used these benefits.⁷ Fear of being reported to the INS was the reason 64% of the women surveyed did not seek social services for which their children were eligible. Several surveys of undocumented immigrants show that the primary reasons they come to the United States are to seek economic opportunity, to flee repression in their home countries, and to reunite with family members.⁸ Quite simply, undocumented immigrants come to the U.S. seeking work, not health care. The legitimate goal of immigration control is best dealt with through border enforcement and other deterrent mechanisms; denying undocumented immigrants access to care will do nothing to help the nation control its borders.

III. THE CIVIL RIGHTS THREAT IN THE HEALTH CARE BILL

A. *The Health Security Card*

The combination of excluding undocumented immigrants from the health care system and the development of a health ID card which everyone except this group will possess creates an enormous threat to the civil rights of all Latinos in the United States, immigrants and native-born U.S. citizens alike. The civil rights implications include discriminatory treatment, denial of services to eligible persons, excessive verification requirements, loss of privacy, and the creation of a *de facto* national ID for Latinos and Asians regardless of immigration status. For example, if individuals seeking medical care are required to show

⁶ *Going to Mexico: Priced Out of American Health Care*, Families USA Foundation, November 1992.

⁷ *Dreams Lost, Dreams Found: Undocumented Women in the Land of Opportunity*, Coalition for Immigrant and Refugee Rights and Services, 1991.

⁸ *Dreams Lost Dreams Found*, op.cit.; *Report on the Legalized Alien Population*, op.cit.

their card in order to receive services, some U.S. citizens and legal residents may be denied access to health care, or experience significant delays, if there are questions about their documents. In practice, the requirement will be applied principally or exclusively to Latinos, Asians, recent immigrants, and others perceived to be "foreign." In addition to differential and discriminatory treatment, these same groups are likely to be scrutinized more heavily than "American looking" people by health care providers, who may have concerns about the validity of their documents. In addition, when Latinos and Asians lose their documents, they are more likely to have difficulty in replacing them because of the fear that they might present fraudulent documents.

In addition, the Clinton Plan's procedures for verifying immigration status are unclear. Latinos, Asians, and others currently experience enormous levels of discrimination in the workplace when employers check documents to verify immigration status under the employer sanctions policy.⁹ Discriminatory treatment includes selectively checking the documents only of Latinos or Asians, or requesting more documents from members of these groups than of others. If the process of administering health care ID cards occurs at any time other than in the workplace, workers will have to undergo an "immigration check" twice, increasing the likelihood of discriminatory treatment. The same is true for non-working Latinos. Some may get their health care cards through the welfare system; those who are neither working nor receiving benefits will have to apply in another location. Any additional procedures which are developed to check immigration status for health care purposes could exacerbate existing discrimination and create new avenues for discrimination to take place.

Perhaps most gravely, the Health Security Card is likely to become a *de facto* national ID card which only some Americans will need to carry at all times. Some members of Congress have already suggested that the health ID card be used as an immigration control document. Even if the use of the card is not expanded beyond health care, any card which is issued only to persons who are legally in the United States, will become a card that Latinos, Asians, and others "suspected of being foreign" will have to carry in order to protect themselves from harassment from law enforcement officials, and to identify themselves for simple procedures like opening bank accounts, and obtaining mortgages. NCLR's President, Raul Yzaguirre, had to carry a card when he was growing up in Texas, as did your colleague in the House, Rep. Kika de la Garza (D-TX). They can testify from personal experience that such a document becomes a powerful tool for discriminating against people on the basis of ethnic appearance, surname or speech accent. Anyone who doubts the passion which this issue evokes should recall the debate on the original Conference Report of the Immigration Act of 1990.¹⁰ Despite the fact that there were major provisions in this legislation which

⁹ *Employer Sanctions and the Question of Discrimination*, U.S. General Accounting Office, March, 1990.

¹⁰ *Congressional Record*, Daily Edition, October 26, 1990, pp. H12980-12987.

Latino members of Congress had fought to include, and the fact that defeating the rule on this legislation in the last days of Congress was very likely to kill the bill, the Congressional Hispanic Caucus led a successful campaign to defeat the rule, because of the bill's inclusion of a pilot program to test a national ID card.

Though the President has made the Health Security Card the symbol of the good things he hopes to achieve through health reform, to Latinos, it is a symbol with a much darker meaning. NCLR has communicated to President Clinton that it is possible to have both a health care card and to avoid discrimination -- even in a system which does not offer true universal coverage -- by issuing a card to every person. If the Administration insists on excluding some members of society from full coverage, it still intends to make emergency services available to all; information about what services are available can be encoded on the back of the card. Unless the Health Security Card is available to all members of U.S. society, regardless of immigration status, it will pose an enormous threat to the civil rights and dignity of the nation's 25 million Latinos, and put the Hispanic community in the untenable position of having to choose between supporting health care reform and protecting its civil rights.

B. Inadequate Civil Rights Protections

The Administration's proposal provides only partial civil rights protection, and leaves Latinos particularly vulnerable to discrimination without remedy. For example, while the Plan provides protection against national origin discrimination, it prohibits health plans but not health alliances from discriminating on the basis of language. The Plan also fails to prohibit discrimination on the basis of citizenship, at the same time that it creates a basis for that discrimination to occur. By excluding the undocumented, the Plan requires providers to distinguish between persons with different immigration statuses. In the employment context, a similar law which requires employers to check the documents of all new hires has resulted in widespread discrimination. The same is likely to happen in the health care context; eligible individuals are likely to experience delays or even denial of health care services because of confusion about their immigration status, or the belief that they are not eligible for coverage. The failure to protect against citizenship status discrimination leaves all Latinos, Asians, and others whose ethnic appearance creates questions about citizenship status subject to discrimination without any meaningful remedy.

IV. CONCLUSIONS AND RECOMMENDATIONS

A. Overview

NCLR believes that, in order to be successful, the health care reform process must result in legislation which fully realizes the goals of providing universal access to health coverage and reducing the cost of medical care. Indeed, the public health of all Americans

is best protected by maximizing coverage and access to health care. While the Administration may believe that it must restrict coverage only to those legally in the United States in order to avoid opening up difficult immigration reform questions in the context of an already complex piece of legislation, by doing so it jeopardizes its own goals for health care reform. Nevertheless, NCLR believes that it is possible to enact legislation which does not specifically bar any group from receiving coverage, nor creates discrimination against any group of Americans. Because the Administration's proposal does not accomplish these principal objectives, were it to be voted on today in Congress, NCLR would be forced to oppose the legislation. However, NCLR remains committed to working with this Subcommittee as well as the Administration to modify this legislation so that it maximizes the number of individuals covered and minimizes the threat to the civil rights of Latinos or any other community. Accordingly, NCLR urges the Subcommittee to consider the following recommendations:

B. *Maximizing Coverage*

There are a number of important modifications which must be reflected in final health reform legislation in order to maximize the number of persons who are protected, and therefore realize the public health and cost savings objectives of health reform. Principal among these is requiring coverage of all persons residing in the U.S. regardless of immigration status. NCLR believes that it is in the best interest of the United States to provide true universal coverage; however, if the legislative process results in some form of immigration restriction to health care, at a minimum, health reform legislation must protect the most vulnerable populations in the interest of saving costs and protecting the welfare of all Americans:

- All persons legally working in the United States must be eligible to participate in the health care system.
- All persons working legally in the U.S. should have access to health care coverage for themselves as well as their spouses and children. Many of the people who would be barred from health benefits under the Clinton Plan are the family members of legal residents who are on their way to becoming legal residents themselves. It is unreasonable to provide health care only to some members of immediate families.
- To ensure the enrollment of eligible members in mixed households, and to ensure the maximum financial contribution from their ineligible family members, absolute confidentiality, including a prohibition on sharing information with the INS, must be assured to all enrollees and family members, regardless of immigration status.
- All children and pregnant women should have access to primary, acute and prenatal care regardless of immigration status. In many states this is currently true; health reform should not result in a reduction in care to these critical populations.

- Rather than explicitly barring any specific groups from health coverage, final legislation should let individual states decide who is eligible to receive coverage. Otherwise, states with large numbers of individuals denied coverage will be placed under an enormous financial burden as they are forced to choose between providing care at their own expense or turning away people in need of medical attention.
- Final health care legislation should allow the Secretary of Health and Human Services to designate special populations for coverage in the case of urgent need, or public health emergency, or when it is otherwise in the public interest.
- In the event that any group of persons living in the U.S. is left without coverage, the funding stream for essential community providers -- such as migrant health clinics and clinics that serve immigrants in urban areas -- must be provided a secure and renewable source of funding, perhaps by levying a surcharge on premiums paid to health alliances.

C. Protecting Civil Rights

It is critical that any health reform proposal enacted by Congress meet two important civil rights tests. First, it must not create new avenues or incentives for discrimination; and second, it must provide adequate remedies for discrimination which may occur in the health care context. Unfortunately, the Administration's proposal does not meet either of these critical tests. In order to pose no threat to the Latino or any other community and to the extent that some form of immigration restriction remains in the bill, final health care legislation must reflect the following recommendations:

- The government should provide an identical health security card to all persons in the United States to avoid discrimination; in the case of individuals who are not enrolled in the health care plan, this information can be encoded on the card.
- Individuals should only be screened once for immigration status; this means that those who establish work authorization for their employers or for public benefits providers should not be questioned again in the health care system.
- Any screening process developed for non-working persons who are not in the welfare system should be straightforward, and include protections against discrimination as well as presumptive eligibility and confidentiality against deportation.
- The health ID card should not be based on the Social Security Number to limit opportunities for its abuse in the workplace and other arenas.
- The law should explicitly prohibit any policy or practice in the public or private sectors that the Health ID card be used for other purposes other than to seek health care through the government's program, with strict criminal penalties and a meaningful private right of action. Additional funding should be authorized for the Legal Services Corporation and its sub-grantees to address any increases in health-related discrimination which may occur as a result of health reform.
- Final health reform legislation must provide full civil rights protections, including protection against discrimination on the basis of national origin, language, or citizenship status.

Thank you for the opportunity to present this testimony today. NCLR looks forward to working with you to enact health reform legislation which truly improves access to health care without causing discrimination.

STATEMENT OF SUSAN B. DRAKE

Mr. WAXMAN. Ms. Drake.

Ms. DRAKE. I would like to apologize to the subcommittee. Due to the quake last week in Los Angeles, I didn't get into the office and so I do have—and other weather conditions here made it a little difficult, so I do have my testimony, my written testimony here to give to the committee members.

This subcommittee's work over the years to protect the health of women, children and other vulnerable populations has really been critically important and I think that the subcommittee's continuing expertise is clearly essential to ensure that health reform meets its lodestar goal of providing universal coverage.

We deal almost daily with questions about immigrants' rights to health care at the National Immigration Law Center in Los Angeles where I work. We are the legal services national support center on immigration issues. We receive calls from not just legal aid attorneys, but hospital social workers, church volunteers, State and local government officials, and many others who ask for our help in understanding the rights of immigrants and their family members to participate in Medicaid and other health programs.

Because of this subcommittee's work to create the Medicaid emergency care provision and sustain other critical health programs, I personally know of dozens of immigrants about whom we have received calls and helped, who owe their health and, in fact, some of them their lives to the subcommittee. We had a 12-year-old boy in northern California who was treated successfully for brain cancer, precisely because the Medicaid emergency care provision existed and then because we were able to get him continuing chemotherapy under the amnesty care provision coverage for children.

I know of a woman suffering a high-risk pregnancy that we had to help in southwestern Ohio, a rural area, who almost didn't have a healthy baby until we were able to enforce her rights to labor and delivery under the Medicaid program.

I can tell you about a young woman in New York who was so brutally battered by her husband that she was placed in long-term care. But she is now going to be able to overcome her disabilities with rehabilitation because she is considered to be PRUCOL or permanently residing under color of law under the Medicaid program.

All of these rights are threatened by the Clinton health care bill as it currently stands. Unfortunately, universal coverage is not really, truly, apparently going to be universal.

We get calls about these kinds of cases not just from the "big six" immigrant States, but from all over the country, from small towns and rural areas as well. Designed properly, health reform could offer us an opportunity to strengthen the kinds of successful interventions I have just mentioned.

Unfortunately, the distortions and xenophobia, which are increasingly characterizing the debate over immigration policy, threatens to overwhelm any rational analysis of what kind of health care policy is in the long-run interests of all of U.S. society. So we have a real difficult dilemma here.

Anyone who knows anything about health policy will tell you that undocumented people should be covered. And everyone who

thinks they know something about politics, will tell you that coverage just isn't politically feasible. We know from a health and a cost perspective that the failure to cover undocumented persons threatens the very success of health reform. Public health is threatened instead of protected. Germs don't ask for a green card. Cost savings are lost.

The failure to enroll almost 3 million undocumented persons in cost-effective preventive care will simply perpetuate inadequate prenatal care and high cost of emergency room admissions. We know, for example, that prenatal care saves \$3 for every \$1 we spend. And cost shifting is perpetuated.

We really are creating a perverse free-rider program where we are planning on taking the tax payments of undocumented workers to subsidize the health coverage of U.S. citizens. And this cost shift, most painfully felt by big cities like Los Angeles and New York, also affects rural areas which don't have the kind of public health infrastructure to serve these folks when they come in.

The attempt that somehow this is good immigration policy, is really misguided. The magnet effect is a myth. Every academic and government study, even the INS study of the amnesty population, shows people come here not to get benefits but to rejoin their family members, flee persecution and better themselves economically.

Throughout the 1980's, Arizona covered all indigent undocumented people in its managed care access system. They had good public health results, they had no appreciable difference in the immigration to that border State.

It is clear that we can do this from experience, not just from theorizing. And mixed families, really, truly cannot—you can't use the law to sever mixed families as if you had a surgeon's knife.

Approximately half of the undocumented live here in mixed households with their citizen and family resident members, and they won't go home, they are home. So what are the dangers in the administration's current proposals?

We have workers who will receive existing coverage because they are not only not covering undocumented workers, they are not even covering everybody who has work authorization. We could create as many as a million workers and dependents who will lose insurance.

Studies show that perhaps about 40 percent of workers in the system now have insurance coverage, which they would lose under the current plan. Emergency care coverage will be drastically reduced.

About 40 percent of women, children and disabled people who are now eligible for Medicaid emergency services will lose services because of the transfer of the noncash Medicaid recipients into the health alliances. Other people getting emergency care will lose their DSH payments because of the proposed phasing out of the DSH program.

And then third, of course there is tremendous concern about the continuing capacity of the community providers as the migrant health clinic, community clinic's funding shifts away from unrestricted funds which they currently receive in an alliance-based funding which might have an immigration restriction.

We have suggestions for improvements that we think can be made in the administration's plan, some of which I have outlined

in my written testimony, others of which are outlined in Ms. Munoz' testimony, and we would look forward very much to working with the subcommittee staff on some of the details of how to provide the kind of coverage that people need.

Mr. WAXMAN. Thank you very much.

[The prepared statement of Ms. Drake follows:]

**IMPACT OF THE PROPOSED HEALTH SECURITY ACT (H.R. 3600)
ON UNDOCUMENTED IMMIGRANTS**

Susan B. Drake
Senior Attorney, National Immigration Law Center
Los Angeles, California

Testimony before the
Subcommittee on Health and the Environment

U.S. House of Representatives
Committee on Energy and Commerce

**HEARING ON THE HEALTH SECURITY ACT (H.R. 3600)
AND SPECIAL POPULATIONS**

January 24, 1994

I want to thank the Subcommittee on Energy and Commerce for inviting me to discuss with you the impact of the Administration's health reform bill, H.R. 3600, on undocumented immigrants. This Subcommittee's work over the years to protect the health of women, children, and other vulnerable members of society has been critically important, and the Subcommittee's continuing expertise and involvement will be essential to ensure that health reform meets its lodestar goal of providing universal coverage.

We deal almost daily with questions about immigrants' rights to health care at the National Immigration Law Center (NILC) in Los Angeles, where I work. As the legal services national support center on immigration issues, we at NILC receive calls from legal aid attorneys, hospital social workers, church volunteers, state and local government officials, and others who ask for our help in understanding the rights of immigrants and their family members to participate in Medicaid and other health programs.

Because of this Subcommittee's work to create the Medicaid emergency care provision and sustain other health programs, I personally know of dozens of immigrants who owe their health, indeed their lives, to this Subcommittee:

- a 12-year old boy in Northern California was treated successfully for brain cancer because of Medicaid emergency care and the coverage for children under the amnesty program
- a woman suffering a high risk pregnancy in southwestern Ohio had a healthy baby because the Medicaid program covers labor and delivery
- a young woman in New York was so brutally battered by her husband that she was placed in long term care; she should be able to overcome her disabilities with rehabilitation services because of full coverage for PRUCOL¹ aliens under Medicaid

¹

PRUCOL denotes persons who are permanently residing under color of law.

We receive calls for health problems like these not just from the "Big Six" immigrant states, but from all over the country, from small towns and rural areas as well as large cities. All of these immigrants were undocumented when they first received care, all of them are now legal or eligible to move toward legal status.

Health reform, designed properly, should offer a rare opportunity to strengthen and expand these successes. Unfortunately, the distortions and xenophobia which have increasingly characterized the debate over *immigration* policy in recent months threaten to overwhelm any rational analysis of what kind of *health* policy is in the long-run interest of all U.S. society.

1. The Undocumented Coverage Dilemma. We have a difficult dilemma here: everyone who knows anything about health policy knows we should cover undocumented persons, but everyone who thinks they know something about politics says this coverage is not politically feasible.

From both a health and cost perspective, the failure to cover undocumented persons threatens the success of health reform:

- **Public health** is threatened instead of protected -- germs do not ask for a green card before they spread. The recent measles epidemic, which struck particularly hard at Latino and Asian children in California, is compelling evidence of everyone's interest in protecting public health.

- **Costs savings** are lost -- the failure to enroll 3.2 million persons in cost-effective preventive care will perpetuate inadequate prenatal care and high-cost emergency room admissions. Prenatal care alone saves \$3 for every \$1 spent.

- **Cost shifting** is perpetuated and a perverse "free rider" problem is created -- the tax payments of undocumented workers will subsidize the health coverage of U.S. citizens, but because these taxes are paid to the federal government, both the undocumented and the state and local governments that try to serve them will be deprived of resources for their care. Big cities like Los Angeles and New York are painfully aware of this cost shift, but it is also a problem in small towns and rural areas that do not have the infrastructure for large public clinic programs.

The apparent attempt to use health policy to create immigration policy is misguided and misleading:

- The **magnet effect** is a myth -- every academic and government study shows that people come to the U.S. not to receive benefits, but to rejoin family members, flee political and other forms of persecution, and better themselves economically. Arizona, for example, provided health coverage to the undocumented throughout the 1980s as part of the state's managed care system without appreciable impact on immigration into the state.

- **Mixed families** cannot be severed as if with a surgeon's knife -- approximately half of the undocumented live here in mixed households with their citizen and legal resident family members. Denying care does not mean that the undocumented go back home, but that home life here -- for everybody, citizen and immigrant alike -- becomes that much more painful.

2. The Danger in Current Administration Proposals. When it became clear last year that the Administration was not going to extend coverage to the undocumented, well-meaning friends said, "Well, what did you expect? At least they'll continue to receive existing services." Unfortunately, the reform plan as currently drafted drastically *reduces* existing coverage:

- **Workers will lose existing coverage** they now receive through employment because H.R. 3600 fails to cover many workers with INS permission to work as well as undocumented workers. As many as 1 million workers and their dependents² may become *uninsured* under the current proposals, damaging not just their health but the financial health of any reform plan.

- **Emergency care coverage will be drastically reduced.** Almost 40 percent of the women, children, and disabled persons eligible for Medicaid emergency care will lose coverage because the bill proposes to eliminate the non-cash Medicaid program. Childless couples and single adults will have increasing difficulty obtaining care as hospitals lose their Disproportionate Share Payments under the proposed phase-out of the DSH program.

- **The capacity of essential community providers will be weakened** as community and migrant health centers, Maternal and Child Health Block grant recipients, public hospitals, and others who now care for the undocumented see their traditional funding streams shift to a Health Alliance-based reimbursement system that excludes the undocumented.

Each of these problems causes grave concern; cumulatively, they spell a public health disaster. We are not discussing here simply a failure to expand coverage, we are talking about a crippling withdrawal of critical health care.

3. Improving Coverage. Several steps for improving the bill are apparent. For example:

- **Cover all immigrants in the U.S. legally.** Inexplicably, despite the Administration's intention to cover citizens and persons residing in the U.S. legally, the bill language fails to cover many workers who have been granted work authorization by the INS, as well as fails to cover many immigrants now receiving Medicaid services under the PRUCOL category.

- **Provide emergency and preventive care.** The Administration's announcement that the undocumented would receive emergency and preventive care was criticized only by those who felt the undocumented should receive full coverage. As indicated above, however, emergency coverage is actually *reduced* under the current proposal. Moreover, no effort is made to maintain the leverage of federal financing for prenatal care and children's coverage, two critical preventive care areas where states have expanded coverage in recent years because of the shared obligation with the federal government to cover emergency costs under Medicaid.

- **Provide secure funding for essential community providers.** Preserving the "safety net" of community clinics, public hospitals, and other community providers is essential not just for immigrants, but also for the homeless, persons with mental disabilities, migrant workers and others who have been marginalized by U.S. society.

We would be happy to work with the Subcommittee and Subcommittee staff to flesh out the technical details of these and other proposals which can help ensure, for the sake of all our communities, that health reform is universal in deed as well as name.

² Approximately 46 percent of undocumented workers have insurance coverage through their employment and an additional 4 percent purchase private plans. INS, *Report on the Legalized Alien Population* (Washington, D.C.: 1992), Table 32; Chavez et al., "Undocumented Latin American Immigrants and U.S. Health Services: An Approach to a Political Economy of Utilization," *Medical Anthropology Quarterly*, Vol. 6, March 1992.

STATEMENT OF RICHARD C. PARKINS

Mr. WAXMAN. Mr. Parkins.

Mr. PARKINS. Mr. Chairman, I thank you very much for the opportunity to testify before the subcommittee.

With your permission, Mr. Chairman, I would like to amend my comments slightly and resubmit a finished testimony.

Mr. WAXMAN. There is really no reason to ask. Certainly you will be granted that opportunity.

Mr. PARKINS. Mr. Chairman, my reflections on this testimony are drawn primarily from my work as Director of Refugee Immigration Policy, the Office of Migration and Refugee Service of the United States Catholic Conference. The United States Catholic Conference through its Immigration and Refugee Services Department is the largest private, nonprofit resettlement and immigration agency in the United States, and so therefore I speak on behalf of that organization and the experience that its history represents.

Last June, the United States Catholic Bishops adopted by unanimous vote a major resolution to guide our approach to health care reform. This resolution reflects a broad consensus among the bishops. In this testimony, I would like to share the basic message of that resolution and some thoughts on populations who are especially at risk as you consider the President's health care reform plan, and other health reform initiatives.

I believe that few communities have more at stake or more to contribute to this debate than the Catholic community. We are major providers and purchasers of health care. In our hospitals, shelters, clinics and parishes, we pick up the pieces of a failing health care system. It is important to say at the outset that we are a diverse community of faith, not a political interest group.

Here in Washington, the battle over health care reform is being driven by political resources that we don't possess, money and power. We bring a different set of assets, strong convictions, broad experience, and a capacity for informed advocacy, which I believe can help shape the health care debate.

We bring to this debate a fundamental set of values and principles. The Scriptures and Catholic social teaching contain key values and principles that guide our health care advocacy. The first principle is a consistent commitment to human life and to human dignity. In our tradition, the human person is the center. A second key principle is our preferential option for the poor and the vulnerable. For us, the key criterion for health care reform is not how it treats the doctors or insurance companies, the well off and the powerful, but how it serves the poor and the unserved, the unborn and the undocumented.

A third key principle is the traditional principle of stewardship. We recognize that there are limits on our national resources, and we know the impact of rapidly rising costs of health care. Stewardship demands effective efforts to restrain rising costs. We accept the premise of cost containment.

A final key principle is our commitment to the common good. In the midst of the partisan battles to come and the inevitable clash of powerful economic interests, we believe that the basic test will be how reform serves the good of the whole Nation, not the narrow interests of the powerful or the partisan needs of politicians, or

even those who now have health care benefits, although we are concerned that these be protected and extended.

These four principles represent our starting points for an ethical evaluation of reform. They help the Catholic community bring a moral perspective to an intensely political debate and offer an ethical framework in an arena dominated by major institutional interests. We are seeking to offer principled and positive advocacy for health care reform that reaches out to the unserved, that protects migrant workers, the undocumented and the unborn, and that also contains costs.

We have shared with the administration and Congress in rather detailed form our criteria for reform. Our criteria emphasize the needs of the unserved, uninsured and unborn. We seek to bring together our principles and our experience in a positive and consistent case for health care reform which enhances the life and dignity of all. It is not our role to be either partisan allies or partisan adversaries of the Clinton administration's initiative. We do, however, welcome the administration's leadership and commitment to reform. We applaud its emphasis and universal access, on disease prevention and on health security. However, we are concerned about recent changes which delay or diminish the commitment to universal access. We take strong exception to the administration's unwise and unjust efforts to exclude undocumented immigrants and to link health care with abortion.

Likewise, we are neither supporters nor opponents of the alternative plans offered by others, one of which is more sweeping than the Clinton plan, and others less so. We welcome the initiative taken by proponents of these plans and look forward to the coming debate. We are concerned that several of the major alternatives are not clear in their full commitment to universal access, and that they share the defects of the Clinton plan in their treatment of the unborn and the undocumented.

Some of our specific areas of concern: Our commitment to universal access and our primary concern for the poor leads us to evaluate any plan based on the extent to which it provides for the special needs of vulnerable populations and helps them to achieve genuine access to a health care system. Among the most vulnerable are the undocumented, migrant workers, the unborn, the disabled and low-income workers.

I would like to speak specifically about our concerns related to the undocumented and migrant workers. It is my understanding that Helen Alvare will give testimony on the National Conference of Catholic Bishops at a subsequent hearing on Wednesday specifically related to women's health issues. She will at that time give more specific and detailed testimony about our concerns on the vitally important issue of abortion. My testimony will therefore focus on the undocumented and migrant workers.

Mr. WAXMAN. Mr. Parkins, that whole testimony is going to be in the record. If you want to make a concluding comment.

Mr. PARKINS. OK. I think that several of the key points that we would want to make is that a major failing of the current health reform initiative is that it does not extend coverage to all persons residing in the United States, regardless of their immigration status. It makes no moral sense to exclude the undocumented immi-

grants because health care is not a commodity, it is basic human right flowing from the sanctity of human right.

We think it is unfair that undocumented workers not be covered by a health plan to which, in many instances, they will actually be contributing since these people are themselves workers. We are also particularly concerned that there would be a decline in health services, particularly for migrant workers, because community health services, migrant health services, would be diminished in support and importance under the Clinton plan and these have been traditional sources of health care support for the undocumented and for migrants.

And finally, a major concern is not in recognizing the health care needs of undocumented immigrants and the inevitable cost shift that will take place to State and local government because sick people will inevitably need health care, they will seek it when it is most expensive and least timely. This will involve a shift of Federal responsibility to local and State government and I think this will further exacerbate the xenophobic feeling that we are now experiencing toward immigrants and migrants and refugees.

So for all of these reasons, Mr. Chairman, we would ask that the undocumented and migrant workers be part of the.

[The prepared statement of Mr. Parkins follows:]

STATEMENT OF C. RICHARD PARKINS

My reflections in this testimony are drawn primarily from my work as Director of Refugee and Immigration Policy for the Office of Migration and Refugee Services with the U.S. Catholic Conference.

Last June, the U.S. Catholic Bishops adopted by a unanimous vote a major resolution to guide our approach to health care reform. This resolution reflects a broad consensus among the bishops. In this testimony, I would like to share the basic message of that resolution and some thoughts on populations who are especially at risk as you consider the President's health reform plan and other health reform initiatives.

I believe no community has more at stake or more to contribute to this debate than the Catholic community. We are major providers and purchasers of health care. In our hospitals, shelters, clinics and parishes, we pick up the pieces of a failing health care system. It is important to say at the outset that we are a diverse community of faith, not a political interest group. Here in Washington, the battle over health care reform is being driven by political resources we don't possess -- money and power. We bring a different set of assets: strong convictions, broad experience, and a capacity for advocacy which, I believe, can help shape the debate.

We bring to this debate a set of fundamental values and principles. The scriptures and Catholic social teaching contain key values and principles that guide our health care advocacy. The first principle is a consistent commitment to human life and human dignity. In our tradition, the human person is the center. A second key principle is our preferential option for the poor and vulnerable. For us, the key criterion for health care reform is not how it treats the doctors or insurance companies, the well-off and powerful, but how it serves the poor and unserved, the unborn and the undocumented.

A third key principle is the traditional principle of stewardship. We recognize there are limits on our national resources and we know the impact of rapidly rising costs of health care. Stewardship demands effective efforts to restrain rising costs.

A final key principle is our commitment to the common good. In the midst of the partisan battles to come, and the inevitable clash of powerful economic interests, we believe the basic test will be how reform serves the good of the whole nation, not the narrow interests of the powerful or partisan needs of politicians.

These four principles represent our starting points for an ethical evaluation of reform. They help the Catholic community bring a moral perspective to an intensely political debate, offer an ethical framework in an arena dominated by major institutional interests.

We are seeking to offer principled and positive advocacy for health care reform that reaches out to the unserved, that protects migrant workers, the undocumented and the unborn, and that contains costs. We have shared with the Administration and Congress our criteria for reform.

Our criteria emphasize the needs of the unserved, uninsured and unborn. We seek to bring together our principles and our experience in a positive and consistent case for health care reform which enhances the life and dignity of all. It is not our role to be either partisan allies or partisan adversaries of the Clinton Administration. We welcome the Administration's leadership and commitment to reform. We applaud its emphasis on universal access, on disease prevention and on health security. However, we are concerned about recent changes which may delay or diminish the commitment to universal access. We deplore the Administration's unwise and unjust efforts to exclude undocumented immigrants and to link health care with abortion.

Likewise, we are neither supporters nor opponents of the alternative plans offered by others, one more sweeping than the Clinton plan and others less so. We welcome the initiative taken by proponents of these plans and look forward to the coming debate. We are concerned that several of the major alternatives are not clear in their full commitment to universal access, and that they share the defects of the Clinton plan in their treatment of the unborn and undocumented.

SPECIFIC AREAS OF CONCERN

Our commitment to universal access and our priority concern for the poor leads us to evaluate any plan based on the extent to which it provides for the special needs of vulnerable populations and helps them to achieve genuine access to the health care system. Among the most vulnerable populations are the undocumented and migrant workers, the unborn, the disabled and low income workers.

I would like to speak specifically about our concerns related to the undocumented and migrant workers. It is my understanding that Helen Alvare will be giving testimony on behalf of the National Conference of Catholic Bishops at hearings on Wednesday specifically related to women's health issues. She will at that time give more specific and detailed testimony about our concerns on vitally important issues such as abortion. My testimony will therefore focus on the undocumented and migrant workers.

The Undocumented and Migrant Workers

Universal access must be the centerpiece of reform. Particular concerns for us are coverage for the uninsured and undocumented. Health care reform must be clearly measured by how it improves care for those now without coverage. It also should be judged by whether it improves or worsens care for visitors, undocumented immigrants, and migrant workers. Coverage of undocumented and migrant workers is important not only for moral reasons but also for public health and cost containment reasons.

A major failing of all current health reform initiatives is their failure to extend coverage to all persons residing in the United States, regardless of their immigration status. It makes no moral sense to exclude undocumented immigrants because health care is not a commodity; it is a basic human right flowing from the sanctity of human life and the dignity belonging to all persons.

Fairness dictates that undocumented workers be covered by the health plan along with others in this society. Undocumented workers are interested in working. They pay taxes as well. Federal, state and local taxes affect undocumented workers and their families just as they do citizens and permanent residents. Yet, under the President's proposal, the undocumented cannot benefit from a health plan financed in part by their own tax remittances.

In addition, under the Clinton plan, some immigrant workers who are in this country legitimately, will not be entitled to health benefits. These workers include: persons who have been granted protection against deportation as family members of people legalized under the 1986 amnesty law, persons granted temporary protected status because of conditions in their homeland, and others granted the legal ability to live and work in this country by the Immigration and Naturalization Service. INS statistics show that as many as 40% of undocumented immigrants may have health coverage through their employers. Those persons would lose access to health care as a result of health reform.

Most undocumented immigrants do not come to the U.S. primarily seeking medical care. There is substantial evidence that undocumented immigrants come to the U.S. primarily for family reunification and for employment reasons. Denying access to health care to undocumented immigrants will not advance the goal of immigration control; and it will endanger millions of people and the communities in which they live.

Even aside from moral arguments, it makes no health policy sense to leave uncovered a population which will continue to require and receive care in the most extreme and expensive circumstances and whose precarious health status could jeopardize the health of the citizens with whom they live. Because

undocumented immigrants will not be eligible for basic or preventive care, they will likely end up in the emergency room to be treated for conditions which could have been treated less expensively through the regular health care system. This undermines not only the public health but also the cost containment goals of health reform. Contagious diseases like tuberculosis do not check for immigration status. The children born to undocumented mothers denied access to prenatal care will be born at greater risk of low birth weight and birth defects, preventable risks with medically costly consequences.

Furthermore, mobile populations like migrant farmworkers must be ensured access to more than emergency and urgent care services at rates which are affordable for such workers. [1323 (c) enrollment of new residents] Migrant health clinics and other clinics which serve immigrants in urban areas will see their funding levels decrease under the President's plan at the same time that they become the only avenue for care for undocumented immigrants and migrant workers who cannot establish eligibility for a Regional Health Alliance through their residence in a state. Besides decreasing the level of funding for these sources of medical care in underserved areas, the plan fails to provide a secure source of funding, since the actual level of financial support will be determined by the annual appropriations process in Congress.

In the absence of coverage, those health care institutions which have historically provided uncompensated care to vulnerable populations, including the undocumented and migrant workers, and which will continue to do so even after reform, must be assured adequate support from state and federal funds to sustain their mission. If such support is not ensured, institutions which traditionally have provided care to the poor and vulnerable, often using their own resources, will no longer be able to meet fully the needs of the communities they serve.

Finally, by explicitly excluding undocumented immigrants from the health care system, the Clinton plan is likely to engender and exacerbate discrimination against immigrants and U.S.-born Americans who may be perceived as immigrants because of their ethnic appearance, surnames, or accents. Health services may be delayed or even denied to persons because of uncertainty about their status or the validity of their documents. We also have concerns about the Health Security Card and the risk of it becoming a de facto national "ID card."

CONCLUSION

It is short-sighted to pretend that omitting a class of needy people from the health plan does anything other than exacerbate a situation and short-change people who are already severely marginalized in this society. Catholic social teaching recognizes the right to adequate health care as a component of human dignity.

It also recognizes that the way we treat those in the greatest need is a measure of our own moral and social well-being. We call on the Administration and Congress to create a real health "safety net" that provides adequate comprehensive care, including access to preventive health services, for the undocumented who live and work among us, but who are truly treated as the "least" of this nation's inhabitants.

This vital national debate is not really about politics - which party gains - or about power - which interest group wins. We believe this debate is fundamentally about children who don't see the day of their birth because of the lack of prenatal care or the tragic violence of abortion. It is about families without insurance, the sick without coverage, communities without care. As the bishops said in June:

"Now is the time for real health care reform. It is a matter of fundamental justice. For so many, it is literally a matter of life and death, of lives cut short and dignity denied. We urge our national leaders to look beyond special interest claims and partisan differences to unite our nation in a new commitment to meeting the health care needs of our people, especially the poor and vulnerable. This is a major political task, a significant policy challenge, and a moral imperative."

Mr. WAXMAN. Thank you very much all of you for all of your testimony.

Mr. Parkins, it seems to me your argument is that we ought to cover undocumented aliens as a matter of morality——

Mr. PARKINS. Yes, sir, it is.

Mr. WAXMAN [continuing]. To protect the human dignity. The First Lady has testified that she is afraid that if we covered undocumented aliens, that would be a magnet, that would bring more people to this country. Do you believe that if they—if people knew they could come here and simply by arriving, however they do it, however illegal it might be, that this may draw more people to the United States?

Mr. PARKINS. No, Mr. Chairman, I do not believe that. I believe basically what Ms. Drake pointed out in her comments, in her testimony. The evidence is overwhelming that immigrants come to this country for reasons of family reunion, for economic reasons, for employment reasons. They do not come for health care benefits. In fact, there is some evidence to support that there are immigrants who have come to the United States who return to Mexico for health care treatment because the health care there is acceptable and is considerably less costly. So no, I do not buy that argument.

And second, as I pointed out in my concluding statement, I think that from a political point of view, if you do not provide a Federal benefit, if you don't provide universal access, this is going to involve a shift of health care costs to local and State government. And I think that rather than a magnet effect, I think it is going to exacerbate anti-immigrant feelings, which of course we of the church are very much concerned about. So I don't accept that logic, Mr. Chairman.

Mr. WAXMAN. I didn't see the program last night, but I understand 60 Minutes had a piece on women who come to the United States for the purposes of giving birth to their children here. We don't provide medical services for undocumented aliens now, except for emergency care. No one could imagine that emergency care means that people are coming here to have an emergency in order to get care.

We do provide natal services for the birth of the babies and in some sort of circumstances public health services. Now, since we do cover the prenatal and birthing services, and I read earlier that astounding statistic, in L.A. County alone, the number of births of people who are here illegally, wouldn't one reasonably conclude that perhaps this is a pretty big draw?

I can imagine it making a lot of sense if you were going to give birth to a baby, you would want to go to the place where you get the best medical care. And as adequate as it may be in Mexico, if you have got a way to get here to get better care here, plus your child's automatically an American citizen—how do you respond to that?

Ms. MUNOZ. I know Ms. Drake and I are both sort of jumping at the bit to answer your question, Mr. Chairman. There is very little to no evidence to suggest that that is a motivating factor encouraging migrants to come.

Women don't come to the United States in order to give birth. There are undocumented women who live in the United States who

have babies here, but the U.S. citizen child is not a motivating factor and the terrific access to health care in the United States is not a motivating factor.

All of the studies which have been done on this subject where people who came in illegally have been asked directly why they came, there have been government studies as well as private studies which show that the reason people come is primarily for family reunification, for—because they are fleeing repression in their homelands or for economic purposes.

There has been a lot of television coverage of this issue. It has been mostly sensational. And in the case of one piece, I unfortunately didn't see 60 Minutes last night, but I am familiar with Leslie Stahl's work on immigration in the past year and it has not been particularly responsible or accurate. 20/20 did a piece on the same subject where they interviewed women who live in Mexico, who had come to the United States in order to have their children, and in every single case those women had a legal right and legal ability to be in the United States.

They portrayed them as undocumented immigrants taking advantage of our system and they provided not one single example of the phenomenon that they claimed they were talking about. This is the kind of stuff that makes terrific television, but it is not really a factor in migration.

And I know Ms. Drake has——

Mr. WAXMAN. I would like to move on to another point, another question.

Under the immigration law passed by the Congress, it is illegal for an employer to hire an undocumented alien. Yet a number of you made the point that undocumented aliens are often working in this country. I presume if they are working, they are working illegally, or at least their employers may be hiring them illegally.

Ms. DRAKE. Not necessarily. I mean, first of all, we did create grandfathered workers. Remember we had a group of workers because ICRA was prospective and not retroactive. It is entirely likely if they have seniority, if they stayed at the same place, it is not illegal to continue to employ them and we may be creating a serious loss of employment benefits for those folks.

And your point is taken of course, we do have an immigration screen. Why create another one?

And we have a whole enforcement mechanism set up and we are going to really have a distortion in the economic incentives if we create an incentive to hire someone who is undocumented because you won't have to give them a benefit that you have to give everybody else.

It is the same argument we have used in order to try to assure that undocumented workers, even though there may be some problem with the actual hiring process, that we are sure that they are covered by fair labor, fair wage, you know, workplace safety.

Mr. WAXMAN. So at the minimum, we ought to make sure that everybody who is working in this country, whatever their immigration status, particularly since they will be contributing——

Ms. DRAKE. Precisely.

Mr. WAXMAN. Presumably out of their salary for all these programs, ought to have the benefit of health care coverage?

Ms. MUNOZ. And I would add to that, so should their families. The way the Clinton bill is designed right now, if you are working even legally in the United States and you have a spouse who doesn't have immigration status or a child who doesn't have immigration status, which is not an uncommon situation, you can't get health coverage for your spouse or your child, when in 2 or 3 years or 5 years they may actually become legal residents. In the meantime, they will be denied access to health care. It ends up costing us more in the long run and unfairly denying people access.

Mr. PARKINS. Mr. Chairman, we may also raise the issue of discrimination here that has been referenced, and I don't think the health care providers themselves should be the screeners. In other words, it should be assumed if a person comes for health care service, that person is entitled to it.

Mr. WAXMAN. Well, I think you have given us a lot of information we have got to think very carefully about. There is no question in my mind that the consequence of not covering large numbers of people who are here as a fact of life, is going to mean that we are going to make sure that their medical problems are going to be much worse, because we are not going to give them primary care and preventive care. Their problems will be much worse.

If we provide for emergency services, as we already do, the cost of that will be more. The costs will be borne by local governments, as the—and those institutions, medical institutions, hospitals particularly, that will see the people.

And then from a public health point of view, we have got to not only protect the individuals, but society as well can be affected by medical problems that don't know immigration status, germs, diseases that can be transmitted that don't check immigration status when they go from one person to the next.

I thank you very much for your testimony.

That concludes our hearing for today and we stand adjourned.

[Whereupon, at 3:59 p.m., the subcommittee was adjourned.]

[The following statements and letter were submitted for the record:]

**STATEMENT ON BEHALF OF
THE AMERICAN LUNG ASSOCIATION
AND
THE AMERICAN THORACIC SOCIETY**

These comments are submitted on behalf of the American Lung Association and its medical section, the American Thoracic Society.

Founded in 1904 to fight tuberculosis, the American Lung Association is the oldest nationwide voluntary health agency in the United States. Along with its medical section, the American Thoracic Society -- a 10,000 member professional organization of physicians, scientists, and other health professionals specializing in pulmonary medicine and lung research -- the American Lung Association provides programs of education, community services, advocacy and research to fight lung disease and promote lung health.

Every year, nearly 310,000 Americans die of lung disease. Lung disease is now America's number three killer, responsible for one in seven deaths. That rank may change. The lung disease death rate is climbing steeply, while the rates for America's first-and second-ranked causes of death, heart disease and cancer (except for lung cancer), are dropping. From 1979 to 1990, the lung-disease death rate rose by 20.6 percent, while the death rate from heart disease fell a dramatic 23.8 percent.

A little over three years ago, and in part because of these grim statistics, the ALA/ATS began deliberating the issue of health care reform, looking at the issue from the unique perspective of

the needs of people with chronic lung disease. In 1992, we formalized our thoughts in a policy statement that was approved by the respective Boards of Directors of the two organizations. A copy of our policy statement is included with this testimony. First and foremost, we support universal coverage for all U.S. citizens and legal residents. The coverage must be portable, prohibit pre-existing condition exemptions, and be affordable as well. The ALA/ATS specifically endorses continuation of an employer-based system that mandates employer participation with mechanisms to facilitate that participation. Our statement also provides details of what we believe a standard benefits package should look like, giving examples of pulmonary-specific benefits. A chart detailing that discussion is located on page 3 of our attached policy statement.

The ALA/ATS endorses H.R. 3600, President Clinton's Health Security Act. We offer the following comments on the legislation, and suggestions to ensure maximum coverage for people with lung disease.

EMPLOYER MANDATE

ALA/ATS Recommends that:

- * an employer mandate be included with subsidies to assist small businesses.**

The ALA/ATS believes any new health care system should be built upon our current public/private system. We support an employer-mandated system in which mechanisms and incentives are established to help employers finance health care benefits for their employees and the employees' dependents. We believe this would be the least disruptive way to achieve

universal coverage, another tenet of our position. Our statement also proposes a list of benefits the ALA/ATS believes must, at a minimum, be included in the employed financed package. Employers should certainly be free to offer benefits above and beyond those mandated. Individuals also should be allowed to purchase supplemental coverage on their own if they so choose.

In the past forty years, Americans have come to rely on their employer as the provider of health insurance. While the Clinton plan does not mandate that the employer choose the one or two plans to be offered to their employees, it does require the employer to serve as the chief or primary contact for the employee to deal with the overwhelming and daunting health insurance system. Workers already are comfortable with that arrangement. The role of the employer certainly changes under the Clinton plan from that of benefits administrator, to more of a facilitator of information. It appears this would be a less time-consuming and less costly role for the employer, while retaining the current relationship with the employee. Individuals who are uncomfortable obtaining health insurance through their employer have the option to work directly with the regional health alliance.

An employer mandate would level the playing field among different employers, most of whom provide such coverage today. It would eliminate unequitable cost shifts that employers bear today for the uninsured workers of other employers, as well as the cost-shift that all payers of health services encounter due to other uncompensated care and inadequate Medicare and Medicaid payments. According to a 1991 Lewin/ICF study on cost-shifting, if all forms of cost-

shifting were eliminated, employer health costs could be reduced by approximately 10 percent. The ALA/ATS does not believe that the health care system should be financed totally by either the government or the private sector. But rather, the current sharing of responsibility is the appropriate way to proceed. We realize that some employers and individuals will need financial help to meet their obligation. Therefore, the proposal for employers to finance partial coverage, with assistance from the government, is ideal. This arrangement does not preclude individual responsibility for paying for a part of his or her health care costs, again with governmental assistance if necessary.

INSURANCE REFORMS

ALA/ATS Recommends that:

- * all pre-existing condition limitations be prohibited,
- * coverage must be guaranteed renewable and guaranteed issue,
- * premiums must be community rated, and
- * the medical portion of worker's compensation be consolidated into the new plan.

The ALA/ATS supports the need for changes in our current health insurance industry to ensure universal health care coverage. Most of these changes are included in the Clinton and other proposals. Primarily, all pre-existing condition clauses or mandated waiting periods must be eliminated. For people with chronic conditions, even a six-month delay in coverage could be catastrophic. If the particular treatment is expensive, the person may become bankrupt in the intervening time, or forego the expensive treatment, thereby increasing the severity of their condition -- and in all likelihood the ultimate cost of treating their illness -- for when they do become eligible for coverage.

The ALA/ATS believes that coverage must be guaranteed renewable and that coverage should not be cancelled for any reason, including nonpayment of premiums. Although every effort should be made to ensure that individuals who can afford to pay for their treatment do so, inability to pay for care must not be the deciding factor in care delivery.

Community rating must also be ensured. People who are sick must have access to the health care system. Charging them more to receive the benefits they need -- which, in fact, the current premium system does -- is inherently wrong. This approach must be changed to a system that treats everyone equally. Many diseases, conditions, or injuries are unavoidable and people should not be penalized for becoming ill or disabled.

The ALA/ATS also supports the consolidation of the medical portion of the worker's compensation plan into the new system. This program has created jurisdictional problems from both an insurance perspective and a health care management perspective; we welcome the president's proposal in this area.

PUBLIC HEALTH INITIATIVES

Medical Research

ALA/ATS Recommends that:

*** additional funding for medical research be ensured through a dedicated revenue source.**

The ALA/ATS is pleased that the Clinton plan includes provisions for medical research. A strong basic biomedical research program is the basis for a strong health care delivery system.

We also believe that health care dollars can be saved in the long-term through improved diagnostic tools and treatments developed as a result of medical research breakthroughs.

The Clinton plan places a new emphasis on medical research in two areas, preventive services and health services research. Although the bill as introduced lists only broad categories for the new research emphasis, an earlier draft included provisions of specific interest to the ALA/ATS such as prevention of dependence on tobacco, research on new vaccines to prevent tuberculosis and to develop better tuberculosis diagnostic tools, and a new emphasis on identifying environmental health hazards. The ALA/ATS is concerned, however, that funding for these new research initiatives is subject to the regular Congressional appropriations procedures, and therefore, is not guaranteed. We support a supplemental, dedicated revenue source, such as the one being advocated by Senators Harkin and Hatfield, that guarantees a new funding pool for basic biomedical research. We would also express caution to ensure that this new emphasis on biomedical research does not detract from or reduce funding for other ongoing, and equally important, biomedical and health services research.

Public Health Programs

ALA/ATS Recommends that:

- * additional funding for public health initiatives be guaranteed.

The Clinton plan is the only proposal pending before Congress that addresses the needs of the public health system. We applaud these initiatives. The plan seeks to redirect the current focus of the nation's public health system away from the direct provision of services, and back toward

the more historical and traditional public health programs that monitor and protect communities from communicable diseases and exposure to environmental and occupational hazards, and identify and control infectious diseases.

We also support the new National Initiatives on Health Promotion and Disease Prevention that are included in the bill. Of specific interest to the ALA/ATS are provisions that allow the Secretary of Health and Human Services to make grants to local government agencies, private nonprofit organizations, and coalitions of such agencies to develop and implement community-based health promotion and disease prevention activities. This is an extension of the current role/relationship that the ALA/ATS enjoys with state and local health departments in many areas. We look forward to continuing and strengthening this important relations.

However, we are concerned as funding for these programs is also subject to the regular appropriations process. In the early 1970s, Congress eliminated funding for public health programs in the area of tuberculosis prevention and control. As a result of this and other breakdowns within the public health infrastructure, we are facing an extraordinary increase in the number of TB cases in the United States, over 20% in just seven years. Funding for these important programs must be ensured, through some type of direct funding mechanism, or exemption from the current cap on discretionary spending.

CONSOLIDATION OF FEDERAL HEALTH PROGRAMS

ALA/ATS Recommends that:

- * all federal health programs be consolidated into the new plan.

The ALA/ATS supports the president's proposal to consolidate the Federal Employees Health Benefits program and the Medicaid program into the new system. We also support the consolidation of all other federally funded health programs into a single entity. We would include in this consolidation programs currently funded through the Veterans Administration, the Department of Defense, the Indian Health Service, the migrant health centers, and so forth. We believe this would eliminate costly duplication of physical structures, equipment purchases, and personnel. This consolidation would also stream-line government functions. Instead of having multiple rules, regulations, and procedures -- not to mention forms -- one single procedure could be used by all federal health systems.

COMPREHENSIVE BENEFITS PACKAGE

Preventive Benefits

ALA/ATS Recommends that:

- * influenza immunization be provided for all at-risk individuals, regardless of age,
- * a mechanism be in place to allow for frequent changes in immunization indications,
- * health education benefits be made mandatory, and
- * asthma education and asthma self-management be covered under health education.

The ALA/ATS supports a uniform package of basic benefits that includes the appropriate levels of preventive, acute, chronic, and rehabilitative care. Although we do not specifically include

long-term care benefits in our position paper, we would also support the inclusion of long-term care benefits in a basic benefits package.

We are pleased to see that President Clinton has included the influenza vaccine and pneumonia vaccine in the preventive benefits section of his reform package. However, we are concerned that the influenza vaccine would only be provided to those individuals age 65 and over. In years such as this current year, when the strain of influenza is expected to be unusually severe, we recommend that ALL individuals at-risk get their influenza vaccine, not just those over 65.

Others at-risk include:

- * health care workers of all ages;
- * residents of nursing homes and other chronic-care facilities housing persons of any age with medical conditions;
- * adults and children with chronic cardiovascular or respiratory disorders, including children with asthma;
- * adults and children who have required regular medical follow up or hospitalization during the preceding year because of diabetes mellitus or other chronic metabolic disorders, kidney dysfunction, blood disorders, or the immunosuppression that can be caused by AIDS or various cancer treatments; and
- * children and teenagers -- from 6 months to 18 years -- who are receiving long-term aspirin therapy, and therefore may be at risk of developing Reye syndrome after influenza.

We recommend that influenza immunization be available to all at-risk populations. The pneumonia immunization is probably appropriate for those age 65 and over. However, as indications for immunization can change frequently, it is important to maintain flexibility. There must be a ready mechanism in the benefits plan to deal efficiently and effectively with these types of necessary changes.

Health Education

The ALA/ATS strongly supports health education as an integral part of preventive health care. These programs will encourage individuals to maintain healthy lifestyles and take responsibility for positive health behavior. However, we are concerned that these benefits are left to the discretion of the various health plans. The ALA/ATS believes these benefits should be mandatory and include provisions for smoking cessation and asthma education and self-management training, among others.

Smoking cessation is imperative in any benefits package. Tobacco is the only product that, when used as intended, causes disease and death. 419,000 deaths a year are attributed to smoking. The morbidity and mortality associated with second-hand tobacco smoke raise the stakes even higher. Maternal smoking during pregnancy accounts for an estimated 20 to 30 percent of low-birth weight babies, up to 14 percent of preterm deliveries, and some 10 percent of all infant deaths. Smoking costs the United States at least \$65 billion each year in health care costs and lost productivity. As a further preventive health measure, we strongly support increasing the excise tax on tobacco products by \$2 per pack.

The ALA/ATS recommends that other health education benefits such as asthma education and asthma self-management be included in a mandatory health education benefits package. Asthma is, in fact, the most frequent reason for hospitalization due to chronic disease in children and teens under age 15. Asthma is also the number one cause of school absences attributed to chronic health problems. If students are taught how to manage their asthma -- what triggers an

attack, how to avoid those triggers, what to do should an attack occur, and how to effectively use their medications -- trips to the emergency room, hospitalizations, and lost school days can be reduced significantly.

The ALA/ATS also believes that comprehensive school health education is necessary for instilling positive health habits in our children. Such a program should include information on health-risk behaviors such as tobacco use and drug abuse, environmental health concerns, personal health, nutrition, and the prevention and control of diseases.

Agencies such as the American Lung Association and the American Thoracic Society are ideally suited to provide leadership in this area. Public education is a primary tool used by the ALA/ATS to fight lung disease and promote lung health. We urge schools, families, health care providers, religious institutions, community organizations, and others to join the voluntary health community in providing comprehensive health education.

Chronic Care and Rehabilitation Benefits

ALA/ATS Recommends that:

- * a wide range of outpatient benefits be provided,
- * oxygen benefits be retained under Durable Medical Equipment,
- * a national coverage policy be established for home oxygen use, and
- * criteria be ensured for rehabilitation services to allow for maintenance or nondeterioration in condition.

Lung disease doesn't always kill. It may simply make each breath barely possible--a constant, moment-to-moment struggle to stay alive. Nearly 26 million Americans are now living -- often

painfully -- with chronic lung disease. At least 15 million suffer from chronic obstructive pulmonary disease (COPD), the fifth-ranking cause of death. COPD includes emphysema, which afflicts approximately 1.6 million Americans, and chronic bronchitis, which affects nearly eight times as many -- 12.5 million people.

Classic emphysema develops over many years of assault on lung tissues. Breathing falters and, ultimately, each breath becomes a chore. In the end, patients are dependent on oxygen, even at rest. The damage, and the disease, are irreversible. In most cases, therapy is limited to relief of symptoms and attempts to improve the patient's general quality of life.

Like emphysema, chronic bronchitis typically develops over many years. Many of those who suffer from it are subject to periodic attacks of obstructed breathing, when their lungs become inflamed and clogged.

Sarcoidosis can attack any organ of the body, but it most frequently affects the lungs. Pulmonary sarcoidosis causes stiffness in the lungs and a decrease in the amount of air the lungs can hold. Although the disease can be found throughout the world, it is particularly prevalent in middle-aged, African Americans. If a case of pulmonary sarcoidosis becomes serious, it can develop into pulmonary fibrosis -- the abnormal formation of fiber-like scar tissue in the lung. This distorts the structure of the lungs and can interfere with breathing. This can result in yet another chronic lung disease, bronchiectasis, in which pockets form in the air tubes of the lung and become sites for infection. Corticosteroid drugs are the primary treatment for sarcoidosis.

Asthma is another chronic lung disease. An attack finds the victim gasping for breath as the airways become constricted. Between 1979 and 1991, the hospitalization rate for asthma rose 24.2 percent. The reasons for this increase are currently unknown but are the subject of extensive scientific investigation. For those who suffer from asthma, treatment typically means a variety of medications, some used regularly to stave off trouble, other to counter acute attacks. They include bronchodilators, corticosteroids and other reducers of inflammation, and a variety of agents designed to minimize allergic reactions. Complying with often complex treatment regimens can prove particularly difficult for children.

Although lung transplantation may be an option for some patients with endstage lung disease, it certainly is not appropriate for all patients with chronic respiratory-related diseases. Most medical care for diseases such as sarcoidosis, and severe COPD, involve proven, highly effective treatments such as periodic physician visits, drug therapies, supplemental oxygen, and, for some, pulmonary rehabilitation. For many of these patients, support groups, health education classes and in some cases, psychological counseling, may be necessary to help teach patients how to live with their disease, and cope with the changes in their lifestyles. Such chronic or "maintenance" benefits are the reality that help these patients live a relatively normal life in their own home.

We recognize that durable medical equipment is covered under President Clinton's plan. We recommend that this include, as has been the case in the past, the administration of supplemental oxygen and supplies needed by many chronic lung disease patients. However, the ALA/ATS would like to see a national coverage policy with respect to home oxygen use. Even within the

Medicare program, there is no national, uniform coverage policy. This gap creates unnecessary confusion for the patient and the providers over what treatment is covered for which diseases and symptoms.

The ALA and ATS would also caution that all forms of successful rehabilitative care do not necessarily affect the outcome of the patient's condition. For patients with chronic lung disease, the major benefits of pulmonary rehabilitation are improvements in quality of life. The objectives of pulmonary rehabilitation are to control and alleviate symptoms and complications and to achieve optimal ability to carry out activities of daily living. Pulmonary rehabilitation may consist of a variety of activities from exercise training to increase breathing capacity, to breathing retraining, energy conservation and nutrition counseling. For many patients, rehabilitation keeps them at an even level, but more importantly it prevents further deterioration in their condition. We hope that such assistive rehabilitations are not lost in the move to cure all patient ills.

ACCESS TO SPECIALTY CARE

ALA/ATS Recommends that:

- * appropriate and timely access to specialty care be preserved.**

Although the American Lung Association and the American Thoracic Society support the need to train more primary care providers, we are concerned that lung disease patients have access to the appropriate specialty care their condition demands. A gatekeeper system that too strictly requires permission/referral for every visit to a specialist would be a large detractor to access for people with chronic lung conditions. Appropriate management of moderate to severe asthma or

sarcoidosis by a specialist, for example, is more likely to result in fewer hospitalizations than care of those same cases by a general internist or family practitioner who does not have the extra, necessary training. For many patients, specialists ARE their "primary care provider." In fact, pulmonary physicians are well trained to assume full care for the patient whose primary problem is lung-related.

BENEFITS DISCLOSURE

ALA/ATS Recommends that:

- * health plans provide full disclosure of benefits.**

Once the benefits package is established, health plans must be required to disclose the full spectrum of benefits, including any additional benefits that may be provided. It is important for individuals, such as people with asthma, to know that they will have access to the range of benefits they need to maintain a healthy life-style, including the correct pharmaceuticals, nebulizers, peak flow meters, spacers, tubing, asthma education, and so forth. These benefits must not only be fully disclosed, but also defined in easy-to-understand terms. Patients must be able to comprehend exactly what they are receiving, or more importantly, be assured that they will receive the benefits they need.

SUMMARY

In summary, the ALA/ATS supports a mandate on employers to help finance health care benefits for their employees and the employees' dependents. The system must include mechanisms that allow and ensure compliance with this mandate. The benefits provided by the employer must

be comprehensive and uniform for all individuals, with the option for either the employer or the employee to purchase supplemental benefits. The ALA/ATS also supports changes to the current system to eliminate cherry picking and other cost avoidance mechanisms used by the health insurance industry. The ALA/ATS supports a strong medical research component and a strengthening of the public health infrastructure, with a secure funding mechanism for each. The ALA/ATS also supports the consolidation of all federal health programs into one single entity.

The ALA/ATS also supports a full continuum of benefits, appreciating the emphasis on prevention, ensuring coverage of benefits for people with chronic conditions to help them maintain a quality of life within the parameters we term "normal," and guaranteeing access to specialty care as is appropriate. Patients must also be made aware of what the full benefits package includes, in detail, and the information must be presented in a way that is comprehensible to the average person.

**Position Statement
of the
ALA/ATS Health Care Policy Task Force**

**REFORM OF THE U.S. HEALTH
CARE SYSTEM**

Founded in 1904 to fight tuberculosis, the American Lung Association is the oldest nationwide voluntary health agency in the United States. Along with its medical section, the American Thoracic Society — a 10,000 member professional organization of physicians, scientists, and other health professionals specializing in pulmonary medicine and lung research — the Lung Association provides programs of education, community service, advocacy and research to fight lung disease and promote lung health.

Based on this mission, we believe our health care system must meet the multiple needs of people with lung disease. It is widely recognized that far too many people are without access to even the most basic of health care services in our current health care system. This structure, therefore, does not meet the needs of people with lung disease or other diseases existing in our society today.

A strong national medical research agenda as well as an effective medical education program are critical to our health care system. However, after considerable discussion, the Task Force agreed that this document was not the proper place to consider these significant yet slightly tangential issues.

The ALA/ATS believes that patients (consumers of health care) and deliverers of health care must have an effective voice in the health care reform debate. As advocates for persons with lung disease and representing people who deliver health care, we therefore call on Congress and the federal government to enact comprehensive health reform that takes into account the principles outlined in this document. We recognize the complexity involved in these proposed changes and the need for a structure to represent the diverse constituencies to implement the changes.

ALA/ATS POSITION STATEMENT ON HEALTH CARE POLICY

The ALA/ATS supports the development of a health care system that will meet the special needs of patients with lung disease based on the following criteria:

ELIGIBILITY

ALA/ATS POSITION: *Health care is a right. Our health care system(s) must guarantee access to a basic level of services for all residents of the United States regardless of employment status, ability to pay, pre-existing condition or other factors such as, but not limited to, age, gender, sexual orientation, or racial or ethnic background.*

We believe health care is a right to which individuals are entitled by virtue of their existence. We recognize and separate this right from those rights that are guaranteed through the Constitution of the United States and the legal system of the United States. Residents of this nation must not be excluded from the health care system for any reason.

Although we believe all U.S. residents must have access to the health care system, we recognize that parameters must be set with regard to the breadth of services provided. For that reason, we support a basic level of health care services to which all residents are entitled. Unfortunately, the United States simply does not have the resources to guarantee unlimited health care coverage to all individuals.

COVERAGE AND BENEFITS

ALA/ATS POSITION: Comprehensiveness — *The basic level of services must be the same for all individuals. These services include appropriate levels of preventive, acute, chronic, and rehabilitative care, and must be provided so as to preserve continuity of care. Access to these services must continue regardless of the cause of illness, or an individual's employment, physical, mental, geographic, or financial state.*

ALA/ATS POSITION: Quality of Care — *The basic level of services should be effective, appropriate, and timely. Medical effectiveness is defined by research findings. Appropriateness is determined by the patient, the family, and the health care team. Timely means without delays that would otherwise adversely affect the outcomes of care.*

ALA/ATS POSITION: Basic Level of Services — *These services should be broad-based and the same for all individuals. Services to be provided are listed on the following page.*

BASIC HEALTH CARE SERVICES TO BE PROVIDED

	<u>Basic Health Services</u>	<u>Pulmonary-Specific Examples</u>
Preventive	Prenatal care Well baby/well child Family planning services Childhood immunizations Adult immunizations Education Periodic health examinations Effective therapies for at-risk populations	TB skin test Appropriate testing for congenital processes (cystic fibrosis, alpha-1 antitrypsin deficiency) TB prophylaxis Influenza, pneumococcal vaccine Smoking cessation programs Pentamidine aerosol (HIV) Screening for occupation- and environment-related pulmonary problems Routine and complaint-specific clinical evaluations
Outpatient	Diagnostic evaluation: history, physical examination, testing, procedures, chronic therapy Prescription drugs	Diagnostic evaluation: routine physical problem-directed history, physical examination Diagnostic testing: radiologic imaging, pulmonary functions Outpatient procedures: thoracentesis, fiberoptic bronchoscopy Ongoing treatment for chronic problems: chronic obstructive pulmonary disease – COPD (chronic bronchitis, emphysema), cystic fibrosis, sarcoidosis, asthma, occupational lung diseases
Inpatient	Extensive diagnostic evaluation Complex treatment of both acute and chronic conditions	Follow-up for positive findings on diagnostic evaluation Treatment for serious exacerbation of chronic problem(s): COPD Treatment for serious exacerbation of acute problems: pneumonia
Rehabilitation	Physical therapy Occupational therapy Supportive care: nursing facilities, home care, durable medical equipment, respite, hospice Mental health services: substance abuse	Physical therapy Occupational therapy Respiratory therapy Pulmonary rehabilitation Supportive care: home care, chronic ventilator care, oxygen

We believe all societal barriers must be eliminated, including jurisdictional questions over coverage, so all individuals have access to the same, uniform set of services and that these services are portable. The guaranteed services should span the continuum of coverage from preventive health services including prenatal and pregnancy care, immunizations, and health screenings to acute services including inpatient hospital care and outpatient services, and chronic and rehabilitative care. In all cases, the services provided must be medically effective as defined through research findings; appropriate as determined by the patient, family and health care team; and timely — without delay due to financial or administrative barriers. We also realize that there are societal interests that may be affected in the provision of care.

STRUCTURE

ALA/ATS POSITION: We favor a health care system that is a pluralistic public/private payment and delivery system. Mechanisms must be established to facilitate the requirement of employers to finance the health care benefits of their employees and employees' dependents. Supplemental benefits can be provided in whole or in part by the employer, or purchased privately by the individual.

We recommend that all federally-sponsored health care programs be consolidated into a single public plan.

We believe the new health care system should build upon our current public/private system. We support an employer mandated system in which mechanisms and incentives would be established to help employers finance health care benefits for their employees and the employees' dependents. Under this proposal, the employer could, for example, provide health care benefits directly as a self-insured program or purchase a group plan as long as the benefits financed by the employer include at a minimum all the services listed in the Benefits section on page 3. Employers would certainly be free to offer benefits above and beyond those mandated. Individuals also would be allowed to purchase supplemental coverage on their own, if they so choose.

It may also be necessary to effect changes at the federal government level with respect to small market insurance laws (i.e., guaranteed issue, guaranteed renewability, community ratings) to facilitate employer compliance. In addition, procedures must be in place to ensure that health care services are provided in instances of jurisdictional coverage dispute (e.g., workers' compensation versus traditional insurance).

We strongly believe that all federally-sponsored health care programs should be consolidated into a single public plan that provides all the services listed in the Benefits section on page 3. This plan would include

SYSTEMIC AND PROVIDER CONCERNS

the Medicare program, Medicaid, Veterans' Administration health programs, CHAMPUS, community and migrant health programs, and so on. It would eliminate the duplications of administration and delivery of services among these many programs. It also would allow for a uniform public program that would not vary by state (as is the problem with Medicaid), and allow access to services regardless of the nature of the illness (as with the VA programs).

ALA/ATS POSITION: Administrative — *The administration of the health care system must facilitate patient access to care. The administrative process of the health care system must be standardized for all payers, thus maximizing resources for actual health care services.*

ALA/ATS POSITION: Provider Reimbursement and Availability — *Providers must be fairly compensated to ensure access to health care. This compensation should reflect provider cost, work, and time. Incentives must be developed to encourage an appropriate distribution between primary care and specialty physicians and a more equitable distribution of health care providers to ensure access to care in rural, inner city, or otherwise underserved areas.*

We believe the system must be "user friendly" and easily accessible to patients. We believe the administrative processes of the health care system must be simplified and standardized for all payers so that more of our health care dollars are spent in providing health care services, and less for paying salaries of people hired to fill out forms. Reforms in this area could include electronic filing of claims, a single uniform insurance form, or "smart cards" for individuals.

We also believe all providers of health care (physicians, nurses, nurse practitioners, clinical nurse specialists, physician assistants, allied health professionals, and hospitals) should be reimbursed at a fair rate so as to ensure full access for patients to all providers. We also believe incentives must be created within the medical education system to ensure the availability of a full range of providers in all geographic regions, especially in areas that are traditionally underserved. A strong primary care network must be developed to act as the entrance point for individuals into the health care system.

To achieve these goals, we make the following recommendations: Improve academic preparation in middle and high schools; provide financial incentives such as scholarships, loan forgiveness or tax credits; revise clinical curricula in medical school to emphasize ambulatory care; equalize compensation between primary care and medical specialties; and reform the malpractice insurance system.

INDIVIDUAL AND PUBLIC RESPONSIBILITIES

ALA/ATS POSITION: Education for health is the responsibility of many sectors of society including employers, schools, families, religious institutions, health providers and voluntary health agencies such as the American Lung Association, the American Thoracic Society, and others. Individual responsibility for health is crucial to an effective health care system. Through proper education individuals will become empowered, active, and aware of their responsibility for positive health behavior and maintenance of healthy life styles.

We believe strong, comprehensive health education programs are an integral part of preventive health care. These programs will encourage individuals to maintain healthy life styles and take responsibility for positive health behavior.

Agencies such as the American Lung Association and the American Thoracic Society are ideally suited to provide leadership in this area. Public education is a primary tool used by the ALA/ATS to fight lung disease and promote lung health. We urge schools, families, health care providers, religious institutions, community organizations and others to join the voluntary health community in providing comprehensive health education.

FINANCING AND COST CONTAINMENT

ALA/ATS POSITION: Financing — The financing of universal health care should avoid placing an inappropriate burden on any individual or particular sector within society and will require a degree of government support. Any premiums, deductibles, and co-payments for the basic level of services should be uniform. An individual's ability to pay shall not be a barrier to care.

ALA/ATS POSITION: Cost Containment — An employment-based health care system of universal coverage can be economically feasible only if there are cost containment features that address both aggregate budget expenditures and provider payments and are applied to all payers.

We believe the health care system should be financed through multiple sources, including the government, with no one sector or individual bearing an unfair or disproportionate share of the costs. We support a progressively financed system and believe that any premiums, deductibles, or co-payments required must be based on an individual's ability to pay.

Finally, we believe cost containment is essential for maintaining a "healthy" health care system and that a variety of tools can be used to rein in the spiraling costs of health care. We suggest tools such as outcomes research, the development of clinical practice guidelines, reform of the medical liability system, electronic submission of claims, a single uniform insurance form, and such other tools as necessary to address aggregate budget expenditures and provider payments.

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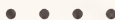
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House Testimony
in Support of the Inclusion of Prenatal Care for Immigrant Women
and Primary Care for Immigrant Children
in Health Care Reform

Equal Rights Advocates (ERA) is one of the country's oldest women's law centers specializing in sex and race discrimination. Over the past seven years ERA has been one of the voices in the women's advocacy community working to bring the issues of immigrant women into the public policy debates on immigration, employment, health care and domestic violence law. Together with the Coalition for Immigrant and Refugee Rights and Services (CIRRS) in San Francisco, ERA helped found the Immigrant Women's Task Force, one of the first groups dedicated to concerns of immigrant women.



As we embark upon the new year, this country is about to tackle one of the most significant policy challenges in decades – the provision of universal access to health care for all. Unfortunately, the health care debate has become inextricably tied to the U.S. economic crisis and policy decisions continue to revolve primarily around the cost of providing services and the issue of who is and who is not deserving of health benefits. This has led to the scapegoating of immigrants, who generally lack political representation and are portrayed as unworthy of access to publicly funded programs. The most immediate victims of this kind of immigrant-bashing are women and children. In California, for example, the governor and several legislators are actively working to cut the few health care services available to undocumented women and children, such as prenatal care and child health services. Excluding this vulnerable group from services jeopardizes the health status of everyone. Thus, we must reorient the discussion on universal coverage toward a visionary goal of meeting the broader needs of society in a way that truly includes all women and children.

Within this context, it is important to keep in mind the demographic realities of the 1990's: America's new immigrants are increasingly likely to be women and children. It has been estimated that 42.3 percent of undocumented migrants to the United States between 1970-1979 were women, and the Urban Institute has more recently estimated that the ratio of Mexican immigrant women to men is 100:130. Although the precise number of undocumented women and children is not known, a study by Equal Rights Advocates based on INS data estimates that approximately 300,000 immigrant women eligible for amnesty under the 1986 Immigration Reform and Control Act did not apply or were denied due to the narrow way in which the law was interpreted and implemented.¹ Many of these women, as well as other undocumented taxpayers, presently obtain health care through a loose network of private and employer-based insurance plans,² and community and migrant clinics.

Under the Clinton Health Security Act (HSA) undocumented residents are ineligible for health care coverage that includes prenatal care and childhood immunizations. This ineligibility precludes undocumented taxpayers from enrollment in any health care alliance or health plan pursuant to the HSA. Undocumented family members (e.g. spouse and children) are excluded as well because legal adult family members cannot confer benefits on family members if they are undocumented. This is a growing problem because after the implementation of the amnesty legislation of 1986, it is not uncommon for families to include a mix of documented and undocumented members. In addition, the bill seems to state that an employer must pay premiums for "qualified employees" whether or not the employee is an "eligible individual". This would mean that employers would be paying for all employees, but not all the employees would be eligible for health care benefits. Due to its limited definitions of PRUCOL (persons residing under color of law) the bill also excludes many immigrants who are in the United States legally and have work authorizations. As a result of this problem the HSA is more limited in its coverage of immigrants than in other legislation where undocumented immigrants are excluded.

The HSA's failure to include undocumented immigrants endangers the realization of the stated principles and goals of the legislation. Health care reform financing projections include the contributions and needs of everyone. The creation of a large ineligible population defeats the very purpose of this ambitious reform of health care. For example,

¹Senate Testimony in Support of SB 1734 to Repeal Employer Sanctions, María Blanco, Equal Rights Advocates; on behalf of the National Women's Coalition to Repeal Employer Sanctions, April, 1992.

²Approximately 46 percent of undocumented persons have insurance coverage through their employment and an additional 4 percent purchase private plans. (INS, *Report on the Legalized Alien Population*, Washington DC: 1992, Table 32; Chavez et al., "Undocumented Latin American Immigrants & U.S. Health Services: An Approach to a Political Economy of Utilization," *Medical Anthropology Quarterly*, Vol. 6 March 1992. As reported in "Immigrants and Health Care Reform," National Immigration Law Center.

- Contagious disease spreads regardless of immigration status;
- Failure to include preventive care such as prenatal and immunizations results in high cost emergency room admissions and therefore the Act's projected cost savings could well be lost;
- 46% of undocumented persons presently have insurance through their employer, if they lose the insurance they currently have more than one million persons and their dependents will become uninsured, in contrast to the Act's goal of ensuring greater access and coverage; and
- Excluding undocumented immigrants from coverage will lead to discrimination against legal residents and self-exclusion by many people of color due to fear.

Although HSA sections 3401-3484 provides that essential community providers will be funded to care for underserved communities and that emergency care for undocumented persons will be continued, these programs are only given \$1 billion annually in the first year and funding will be decreased to the point that in the fifth year funding will go down to about \$240 million. The status of essential community providers after the fifth year is not clear in the HSA, but all the signs indicate that these providers will be highly vulnerable to even deeper cuts or subject to elimination. Currently, the Public Health Services Act (sections 329-330) requires community clinics to provide prenatal care and immunizations, but due to funding cuts and the development of new funding mechanisms proposed in the HSA, the clinics may not be able to serve the communities they were created to serve. To underscore this point, Surgeon General Elders at a recent appearance in San Francisco noted that the present bill's failure to cover preventive prenatal care and immunizations will most likely result in a gap in coverage that could lead to additional health costs in the millions.³

It is for all the above and following reasons that we believe health care reform efforts in this country must, at the very least, ensure prenatal care for women and primary health care coverage for children.

Prenatal Coverage

Health care providers, public health advocates, the judiciary, and numerous legislative bodies, including the U.S. Congress and the states of California and New York, have long recognized the health-related, moral and economic advantages of providing universal prenatal care to all residents of the United States. Whatever their mother's immigration status, today's healthy babies are our

³California Women Lawyers, "Health Care Reform and Women," Keynote address by Dr. Elders, January 27, 1994 San Francisco, California.

country's future: they are future U.S. citizens, tomorrow's labor force, wage earners, tax-payers, and stewards of the this country's social and economic well-being.

- ◆ Every \$1.00 spent on prenatal care saves \$3.00 in a baby's first year of life alone by preventing infant mortality and morbidity, prematurity and low birth weight that often results in the need for expensive hospitalization and remedial care. Thus, projected cost savings will not materialize by cutting these services. On the contrary, eliminating prenatal services in California could cost the state \$120 million a year or more.⁴ Even the courts have contended that "...there can be little question that denying prenatal care...to aliens undermines the clearly expressed Congressional purpose of curbing expenditures."⁵
- ◆ Due to the fact that federal and state law prohibits doctors and hospitals from turning away women in labor regardless of their immigration status, eliminating prenatal coverage would simply raise the financial and human costs to our society.
- ◆ The explicit exclusion of undocumented women from coverage under the Clinton Health Security Act could lead to the elimination of state programs that currently provide prenatal coverage for all eligible women regardless of immigration status. For example, California has been providing family planning and pregnancy related services for undocumented women as part of the state's MediCal program since 1988 and New York state has covered undocumented immigrant women for prenatal care since 1986.
- ◆ Denying children who will be born in the U.S. prenatal care based upon their mother's immigration status will have a direct and adverse impact upon the health of a particular class of this nation's future citizens. This policy irrationally discriminates based on immigration status and may therefore be unconstitutional.

Primary Care for Children

- ◆ The United States ranks twentieth in the world in infant mortality and seventeenth (17th) in the percentage of one-year olds vaccinated against polio and seventieth (70th)

⁴Planned Parenthood Affiliates of California and the American College of Obstetrics and Gynecology, August 1993.

⁵*Lewis v. Grinker*, 965 F.2d 1206, 1219 (2nd Cir. 1992).

for non-white infants.⁶ Lack of care for mothers and the difficulty children of undocumented parents will have in obtaining their rightful care will only exacerbate these problems.

- ◆ Childhood diseases such as measles, mumps, whooping cough and rubella are highly infectious and therefore it is sound public health practice to protect children through immunizations. Universal immunization, though, only works if it truly universal. A comprehensive vaccination program would protect adults from getting these diseases and protect children from chronic health problems associated with these diseases.
- ◆ Every dollar expended on the MMR vaccine (measles, mumps & rubella vaccine) saves \$14.00 in societal costs (e.g. medical costs, loss of work and school days).⁷
- ◆ It is in the interest of all children to have their classmates and playmates able to access health care to prevent the spread of disease and infection. Immunization campaigns only work if all children are vaccinated. Moreover, failure to properly treat chronic conditions like asthma and diabetes leads to greater and more costly use of hospital emergency rooms.
- ◆ Coverage for undocumented children involves low cost and low numbers. Children constitute only about 10% of the country's undocumented residents.⁸ Many of these children will eventually be able to legalize their status through the family visa process.
- ◆ Special efforts should be made by health care providers to reach immigrant children because of their increased vulnerability to childhood diseases due to substandard living conditions, low socio-economic status, and poor nutritional status.

⁶Somerville, J., *Caring for the Children*, Am. Med. News (Feb 1, 1993). As reported in "Universal Health Care and the Undocumented" by the National Immigration Project of the National Lawyers Guild, Inc.

⁷Public Health Service Office of the Assistant Secretary of Health: *Measles Epidemic: The Problems, Barriers and Recommendations*. National Vaccine Advisory Committee, Washington, DC 1991.

⁸California Perinatal Network of Alameda/Contra Costa County, "Protecting Immigrant Health Care in California, 1993."

Conclusion and Recommendations

Under the Clinton Health Security Act, pregnant undocumented women and many immigrant children are threatened with losing access to care they now receive due to the exclusion of undocumented immigrants from basic health care coverage and changes in federal funding mechanisms proposed in the bill. In addition, the care pregnant undocumented women and immigrant children now receive from the "safety net" of essential community providers (e.g. community and migrant clinics) is threatened due to deep funding cuts over a five-year period that will leave these providers severely underfunded and subject to extinction.

In order to provide necessary prenatal care for undocumented women and primary health coverage for immigrant children we propose the following:

- ▶ Create a federally mandated and federally funded limited health care package that includes prenatal care and primary health care for children and is made available to all residents of the United States.
- ▶ Ensure that all workers with health care coverage be able to provide coverage to their spouses and children, regardless of immigration status.
- ▶ Provide a secure, self-renewing source of funding for essential community providers (e.g. community and migrant clinics).

It is imperative that all of us working for better and more effective health care promote universal access for all residents regardless of race, sex, or immigration status. Providing basic health care to all persons who reside in the United States is a public health necessity and the cornerstone of a national commitment to cost-effective preventive health care.

WRITTEN TESTIMONY OF
DAVID R. SMITH, M.D.
COMMISSIONER OF HEALTH
STATE OF TEXAS

Chairman Waxman and members of the Subcommittee on Health and the Environment, I appreciate the opportunity to submit my testimony on the need for the U.S.-Mexico Border Health Commission. Governor Ann Richards and I believe that binational cooperation is essential to meaningful improvements in the health of our border residents. We believe creation of a U.S.-Mexico Border Health Commission is an important issue for Texas and for the rest of our country.

Nine and a half million people who live along the U.S.-Mexico border will benefit from the commission's work. I believe H.R. 2305 will demonstrate that Congress, the President, federal agencies and the states will have a mechanism to deal with the environmental and health problems on the border. Creation of this commission will foster greater coordination and cooperation among public health officials all along both sides of the border and will give the tools they need to address a very real public health crises.

Health and environmental problems neither recognize nor respect geographical or political boundaries. There are unique problems resulting from proximity to a developing country, from special populations and from poverty. More than 35 percent of the border population is uninsured. Basic health care and emergency services are lacking. Seven of the 15 Texas border counties have no hospital. All 15 have some "medically underserved" designation. More than 344,000 migrant/seasonal farm workers call the border region home. Their low economic status and their need to follow the harvest throughout the United States complicate their access to medical care.

Many experts believe the rapid increase in border population is at least partially responsible for the increase of communicable diseases in other parts of the country. Already

we have documented cases of measles being carried far into the interior of the United States, causing catastrophic illnesses for some families hundreds or thousands of miles away from the U.S.-Mexico border.

We must join with Mexico in a coordinated public health effort. The commission would be comprised of the top public health officials, physicians and other experts from both countries who would develop strategies to combat the high incidence of illness caused by the environment and communicable diseases. Preventive and educational efforts would occur simultaneously across the narrow border.

The U.S.-Mexico Border Health Commission should be coordinated with the NAFTA Border Environment Cooperation Commission whose mission only covers environment infrastructure and statistics. Health status is closely linked to environmental conditions. An adequate environmental infrastructure is critically needed and is Texas' first priority.

The most urgent need is for wastewater programs in the colonias and other border communities. Until we get the sewage treatment plants built and the pipe installed, there will be no solution to the public health crisis in the border region. Hundreds of thousands of U.S. citizens will continue to live without indoor plumbing. We need these programs authorized and funded.

Another joint effort this commission could sponsor is the border laboratory being sought by the Texas Department of Health. This lab will provide a much needed environmental and human testing capacity in and for an area of this nation plagued by disease born of dirty water, untreated sewage and pesticide contamination. This first-of-a-kind laboratory will give public health professionals and environmental regulators the technical and

scientific tools needed to unravel the insidious link between pollution and disease.

Not only will the lab give the United States a foundation from which to build bilateral health initiatives with Mexico, it will be the first dual function facility equipped to look at the effect of pollution on humans and on the environment. The lab will analyze samples from two federal agencies: the Department of Health and Human Services (through the Public Health Service and the Food and Drug Administration) and the Environmental Protection Agency.

As commission members develop strategies to combat the high incidence of illness caused by environmental problems—including poor water infrastructure systems, pollution and toxic chemicals--the need for creating a chain of evidence between the environment and humans will necessitate much more laboratory testing that looks at the air, water and soil and at the humans affected.

Congressman Ron Coleman's legislation to establish a U.S.-Mexico Border Health Commission will provide a long-overdue focus of attention and federal funding on the health and environmental problems along the U.S.-Mexico border. The Congressional Border Caucus—with the assistance of each state's medical association and health commissioner—is working for passage of this legislation.

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February 7, 1994

Chairman Henry Waxman
Subcommittee on Health and Environment
House Energy and Commerce Committee
2415 Rayburn House Office Building
Washington, D.C. 20515

Attention: Kristen Eberler

RE: Health Care Reform and
Underserved Populations: The
Federal Obligation to Preserve
and Enhance Indian Health Programs

Dear Chairman Waxman:

We have participated in numerous National Indian Health Care Reform meetings and discussions in the past 12 months. We have also reviewed the National Congress of American Indian (NCAI) December 3, 1993, resolutions regarding the Health Security Act, and January 31, 1994, testimony of NCAI and the National Indian Health Board before the Senate Committee on Indian Affairs. While we are writing specifically in behalf of our low-income American Indian clients, we are confident that our views are largely shared by national Indian leaders.

We ask that the following comments be added to the record of your January 24, 1994, hearing on Health Care Reform and Underserved Populations. This letter discusses the unique obligation of the federal government has to promote and enhance the current Indian health care delivery system and two major problems that we see with the Administration's Health Security Act: inadequate financing for Indian health programs and the potential adverse impact of the Act's underserved populations initiatives on Indian health programs.

The Federal Government Is Obligated To Enhance Indian Health Programs

The Administration's Health Security Act, H.R. 3600, expressly acknowledges the unique status of Indian health programs, but further reduces funding to underfunded Indian health programs and

apparently allows them to be abolished if, after a five year period, they cannot successfully compete with other federally-supported health providers. We are greatly concerned that federal proposals for health care reform have not adequately recognized the federal government's moral and legal obligations to provide health care for Indians and Alaska Natives.

The federal government's unique obligation to provide health services to American Indians and Alaska natives should not be jeopardized by including the Indian health issues in with the Health Care Reform plans for other rural and urban populations. Nor should health care reform be used to further cut back resources to Indian health consumers who presently receive 54% or less of the current level of services they need through Indian Health Service programs.

Congress and the federal courts have protected the sovereignty of Indian tribes for 170 years. Congressional statutes and appropriations have been used to provide health care for Indian people even longer. The promise of health care was a major element of the treaty negotiations of the last century, in which Indian tribes ceded vast tracts of land to the federal government and non-Indian settlers. Senator Inouye calls health services to Indian people "the nation's first prepaid health plan."

The Indian Health Care Improvement Act of 1976 was Congress' first attempt to codify the broad scope of the federal obligation to provide health care to Indian people. It does not repeal or replace the earlier treaties or congressional declarations. The 1976 statute does provide a useful definition of the federal government's obligation to provide Indian health care, which should not be overlooked during the current health care reform debate:

(a) Federal health services to maintain and improve the health of the Indians are consonant with and required by the Federal government's historical and legal relationship with, and resulting responsibility to, the American Indian people.

(b) A major national goal of the United States is to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level and to encourage the maximum

participation of Indians in the planning and management of those services.

25 U.S.C. §1601

The federal government has committed itself to providing localized, culturally appropriate health services to Indian people and to assuring that the services are increasingly provided by *Indian professionals* and, at the tribe's option, *through Indian-controlled programs*. While inadequate funding has been a chronic problem, not until the current health care reform debate has the federal government ever wavered in its support for independent Indian health programs.

The importance of culturally-appropriate health services for Indian people, especially for the many of our clients who are elderly, cannot be overemphasized. They need health services which are based in their community and where Indian culture is understood and respected. Many tribal elders need interpreters for languages that are unwritten. Fluent English is spoken by relatively few. It is not fair to them to be forced to turn to by health care providers who do not possess the deep and broad sensitivity of existing Indian health programs.

Inadequate Financing Will Jeopardize Indian Health Programs And Threaten The Viability Of Many Tribal Governments

There is no question that the Administration's health care reform bill, the Health Security Act (the "Act"), H.R. 3600, would have a significant effect upon the relationship between the Indian Health Service ("IHS") and the Indian tribes which it serves. We believe that financing of the initiatives contained in the Act will determine whether or not the Administration's plan will benefit or harm Indian and Alaska Native tribes and tribal members, and whether its provisions otherwise threaten the continuation of Indian health programs.

We have good reason to be skeptical of the level of financial support that the Administration intends to extend to Indian tribes and the IHS. While H.R. 3600 contains many worthwhile objectives, without proper financing none of those objectives can be attained and Indian programs could be further cut. We believe that the Administration, in light of its own special trust relationship with Indian tribes, has the responsibility to assure that none of the changes proposed in this Act detrimentally affect IHS or tribal programs.

Under H.R. 3600 the IHS and tribes (operating programs pursuant to P.L. 93-638 contracts and Self-Governance compacts) would provide a core level of benefits, the Comprehensive Benefit Package ("CBP"), to all Indians (and other eligible beneficiaries, as described in Section 8306 of the Act) who enroll in the IHS system. The Act would also require the IHS and tribes operating programs pursuant to 638 contracts and Self-Governance compacts to provide supplemental benefits to all eligible Indian beneficiaries whether or not they enroll in the IHS system (Section 8306(c)(2)(A)). (The supplemental benefits are those benefits and services which the IHS currently provides in addition to those contained in the CBP, such as community health representatives and environmental and sanitation services.)

We are also concerned that the Act does not properly take into account the government-to-government relationship between Indian tribes and the federal government. For instance, the Act provides a number of incentives to states which choose to undergo reform prior to the January 1, 1998, deadline. No such incentives, however, are extended to tribes or the IHS.

To the extent that H.R. 3600 provides states, but not tribes, with the financial, logistical, and infrastructural support necessary to provide the benefits guaranteed under the Act, tribal members will doubtless be tempted to opt out of the IHS system for better coverage under private health plans. When one further considers that the Act encourages states to undergo reform prior to 1998, but requires the IHS and tribes to wait until 1999 for reform, there is no question that Indian tribes and states will not be competing on a level playing field. If there is a mass exodus of Indian beneficiaries from the IHS system, then Congress will likely reduce IHS and tribal funding and the future of Indian health programs are jeopardized. Significant reduction or loss of a tribally operated or community based Indian health program would almost certainly deal a crippling blow to many tribal governments.

H.R. 3600 Funding Is Inadequate To Meet Current Estimates Of Need; Better Data Is Necessary To Determine Actual Need

The authorized annual appropriations for Indian health programs under Section 8313 of H.R. 3600 is between \$40 and \$200 million. These appropriation levels virtually assure that IHS health programs will fail to meet Act's certification requirements by 1999, or by any other date. IHS estimates, conservatively, that renovation and construction of tribal facilities to make them adequate to deliver the Comprehensive Benefit Package would cost \$3.5 billion, and that the costs of delivery of the services (aside

from upgrading facilities) may be \$2.3 billion, which would require an additional \$1.1 billion in revenue to add to current IHS yearly appropriations for similar services. Only 49% of current needs are being met by present IHS appropriations. For example, the IHS sanitation program (part of the supplemental benefits assured under Section 8303) is presently underfunded by \$1.64 billion, but IHS is budgeting only \$600 million over the course of a 10 year plan to meet this need.

As discouraging as the preliminary cost estimates are, they may actually underestimate the funding gaps Indian health programs face under H.R. 3600. An actuarial analysis of estimated revenue costs and savings has been contracted for by IHS, but will not be ready for several more weeks. We strongly urge this Subcommittee to carefully review the forthcoming IHS actuarial data and allow further comment from the Indian community once that information is released. Similarly we ask that the Subcommittee allow further comment once the Administration's FY 1995 IHS Budget Request is released.

The Act's Underserved Populations Initiatives Will Put Tribes At a Disadvantage

We would like to draw the Subcommittees' attention to two related provisions of H.R. 3600 which further threaten Indian health programs and, by extension, the future of many tribes: the "essential community provider" and "underserved populations" sections, intended to improve services to underserved areas, would particularly place Indian health programs at a considerable disadvantage in competing with other service providers available to Indian health consumers. The two provisions further suggest that Indian health monies could be withdrawn if the Indian programs were not able to demonstrate, in competition with other providers, their superior service delivery and cost effectiveness.

The "essential community provider" concept would allow a "health program of the Indian Health Service, a service unit, a tribal organization, or an urban Indian organization operating within a health program" to choose to become an essential community provider ("ECP") and enter agreements with non-IHS health plans to provide health services to Indian consumers who choose not to be covered by an Indian health plan (Sections 1582, 1431) and, under some circumstances, to non-Indians (Section 8306).

The "essential community provider" status is intended to assure that existing health programs are not excluded as health providers to their patient community by new private health plans.

It is also intended to assure that the existing health programs are not paid less than other health providers. The ECP status may have little impact on Indian health program numbers as those who have opted out of an Indian health plan are not likely to want to be served by the same Indian health provider under a non-IHS health plan, and we do not anticipate that Indian health programs will be serving any significant numbers of non-Indians.

Some negative elements of essential community provider status may be that: (1) the protection for the providers lasts only five years (Section 1432), after which time the protection may end if the non-IHS health plan demonstrates adequate capacity to also serve this population; and, (2) Under Section 8306(c) Indian programs which choose to be essential community providers must make their services available to family members who are not now eligible for IHS services, and who cannot or choose not to enroll if an Indian program has otherwise opened eligibility to family members under Section 8306(b). In addition, the Act would allow IHS, as well tribes, to enter into agreements to provide health services to general non-Indians populations (Section 8306(a)). These ECP provisions which would require service to non-Indian spouses, step-children and others related by blood or marriage, and could result in IHS (without tribal consent) contracting to provide health services to other non-Indians, have long been a subject of debate within the Indian community. We believe a majority of tribes would not wish to so open their health plans to non-Indians at this time.

Under the present statutory resolution of this issue, long sought by tribes, the tribes now have the option of including non-Indian family members in their Indian health programs and of serving non-Indians on a fee-for-service basis. 25 U.S.C. §1680c. Such service to non-Indians, however, is conditioned upon tribal consent. Any decision made concerning service to non-Indians should also be made only with tribal consent.

The second structural provision of the Health Security Act that would put Indian health programs at a competitive disadvantage is the infusion of federal funding into new health plans for underserved populations under the Act's Public Health Initiatives (Sections 3401-3462). Similar to the essential community provider provisions, the underserved populations initiative would give tribal health programs, migrant health programs, and community health centers a five year period to demonstrate that they can perform to the satisfaction of the health alliance in serving their health consumer population. If they are not cost effective and otherwise adequate in service to the population, the health plan could, after five years, contract instead with other health

providers who have shown an ability to serve the same population adequately on a more cost effective basis. Preference in applying for plan status and financial incentives are given to the new health plans, while community health program funding would be reduced. Sections 3401, 3421, 3441, 3461. Indian programs get little community health center funding in any event thus the advantage to the new plans over the tribal programs is even greater.

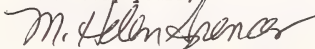
The Administration already presumes that upon implementation of the Health Security Act many Indian health consumers would be served by non-Indian health plans and networks (developed under the underserved population initiatives), and appears to use this presumption to justify less initial funding for Indian health programs under the Act. The adverse impact of the Act's underserved populations initiatives on Indian health programs could be immediate.

The underfunding of Indian health programs means that they will not be able to offer the same level of care as better funded, non-Indian health providers. This means that Indian health consumers will, in time, be forced to choose between community-based, culturally appropriate, but severely limited, Indian health programs on the one hand, and well financed, comprehensive programs that are based outside the Indian community programs. These would be programs which have little or no experience in addressing the cultural needs of Indian health consumers and which will have little incentive to do so. Any added geographic distance to health services would create further access problems for Indian people.

We hope that our comments will be of assistance in helping the Subcommittee understand the different, unique status that Indian health programs have in our Nation's history. There are ample and persuasive legal, moral, and practical reasons why Indian health services should continue to be provided to Indian people by Indian-controlled health programs, including recognition of the sovereign governmental status of Indian tribes and recognition that community-based, culturally appropriate health services can better meet the health needs of most Indian patients than can more generalized health plans and providers. Health care reform should not be allowed to repudiate the many treaties, statutes and court decisions that form the basis for our country's Indian health care programs and assure the right of self-determination for American Indians and Alaska Natives. Finally, we urge you to solicit

further comments from tribal leaders and organizations once the full information on the IHS current budget and new estimates for the Comprehensive Benefit Package are available, and throughout the process of Health Care Reform.

Sincerely yours,



M. Helen Spencer for herself
Evergreen Legal Services
Native American Program and

Thomas N. Tremaine
Spokane Legal Services and

Steven C. Moore
Native American Rights Fund
Support Center

cc: National Congress of American Indians
National Indian Health Board

HEALTH CARE REFORM

Essential Providers, Academic Health Centers, Health Workforce, and Geographic Issues

TUESDAY, JANUARY 25, 1994

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:10 a.m., in room 2123, Rayburn House Office Building, Hon. Henry A. Waxman (chairman) presiding.

Mr. WAXMAN. The meeting of the subcommittee will come to order. Today's hearing is about some of the problems we must solve if we are to make the promise of universal coverage result in the reality of universal access to qualified providers.

We must assure that essential community providers are there when people need them. We must assure that people in rural areas have health services available. We must maintain a system that trains high-quality health professionals to serve us all.

With any change comes controversy. Shortly we will hear testimony from organizations sympathetic to the goal of reform, but critical of the method or the timetable for achieving reform. Some believe the schedule for shifting graduate medical education dollars from specialty to generalist training is too ambitious.

They prefer a slower transition that takes advantage of market forces but then may delay fundamental change until well into the next century. The President's bill singles out several categories of providers for short or long-term protection, but we will hear that the bill leaves some vital providers, such as children's hospitals and trauma care centers potentially vulnerable.

Additionally community and migrant health centers and other primary care clinics, such as family planning or Ryan White Clinics, have only time-limited protection despite the fact that they are likely to be primary providers in many communities for a long time to come.

The President's bill also provides special financial protection to academic health centers and their teaching hospitals and clinics. These institutions carry out the education of our health professionals, conduct biomedical research, and provide both basic and specialty care to millions of patients.

In return, the President's bill asks these institutions to help implement a new national policy that will increase the number of primary care practitioners, reduce the number of highly specialized

practitioners, and bring our overall supply of health professionals in line with the needs of a reformed health care delivery system.

I believe these policies are essential if we want to meet our health service needs and moderate the growth in health costs. Some critics, however, believe the proposed level of financial support for graduate medical education and the other special roles for academic health centers is inadequate to sustain America's continued world leadership in health research, training, and health care quality.

We certainly need to make sure that during the transition to these new work force policies, that teaching hospitals and academic health centers have sufficient resources to continue their important roles.

Finally, we are fortunate to have a panel of especially well-qualified representatives of rural health providers. Key to our strategy for reaching underserved populations, both in terms of facilities and the availability of health professionals, is a plan for serving rural residents.

A critical component of any such plan is full funding of the National Health Service Corps, expansion of rural clinics, development of information technology, and other practitioner support mechanisms, and new Federal assistance to create community health plans and assure enabling services as called for in the President's bill.

As always, these advances require investments. While the President's bill provides significant authorization increases for many of these initiatives, it is unlikely the needed funds can be appropriated within the existing caps on discretionary spending.

I am committed to working with the administration and others to guarantee the funds for these initiatives and to do so in a way that does not undermine current support for public health programs.

Before calling our witnesses, I would like to recognize the distinguished ranking member of the subcommittee, Mr. Bliley, for any opening statement he may have, and without objection, all Members' opening statements will be included in the report in full, but I will be calling on Members who wish to deliver an opening statement.

Mr. Bliley.

Mr. BLILEY. Thank you, Mr. Chairman.

During our many hearings on the Clinton Health Care Act, I have continually pointed out that the Consumer Price Index premium cap in this bill would create in this country a tighter spending control system than that of any other western nation.

No nationalized system in the western world has come close to limiting spending to the CPI, and we have seen in countries like Great Britain and Canada that price controls and global budgets always lead to health care rationing, particularly for the elderly and the chronically ill.

In Britain we know the elderly are routinely denied high-tech, life-sustaining treatments, such as kidney transplants, and we know that our Canadian neighbors had to shut down their hospitals during Christmas for two weeks because the government ran out of money.

Today we are going to explore another type of rationing, the rationing of specialized medical knowledge for our young doctors. For you see, in the brave new world of the Clinton health care system, the government will prevent tomorrow's future doctors from learning about the most advanced medical procedures by limiting access to specialty programs.

The administration is proposing to seize control of our Nation's medical schools and restrict medical education of specialists by government fiat. The Clinton medical educational rationing provisions would require that by 1998 no more than 45 percent of medical graduates be permitted to go on to advanced training in a specialty.

Specialty programs at our leading medical schools will have to drastically downsize and then young doctors will be assigned to these coveted specialty programs based partially on race and ethnicity, depending on how under-represented each racial or ethnic group is in the various medical specialties.

This command and control regulatory approach to physician work force training is deeply disturbing for several reasons.

First, restricting medical education is a clear attempt to reduce consumption of expensive state-of-the-art medical care. Clearly, doctors who are not trained in sophisticated technology cannot use it. This will have a particularly adverse effect on the Nation's elderly Medicare population who depend on our Nation's specialists for their lifesaving treatments.

During the next several decades when the elderly population will grow dramatically, these government limits on medical training will deprive the elderly of access to new procedures. This points to the direct link between the rationing of medical training and knowledge and the rationing of high-tech specialty care.

Second, at a time when medical knowledge is growing exponentially, when scientists are attempting to map the human genome and neuroscientists are unlocking the secrets of the brain, we are going to force our next generation of physicians into a primary care quota system.

Government officials and physician bureaucrats are finally going to obtain their ultimate goal to have absolute power to dictate the career choices of tomorrow's future physicians. Is it really true we need less care by specialists? Not according to a recent NIH panel which reported that primary care physicians frequently overlook the early signs of kidney failure and fail to make a proper referral to a specialist.

The NIH said that the patient should be referred to a specialist for dialysis sooner before it is too late to save their lives. The chairman of the NIH panel, Dr. Craig C. Tischer, warned that patients with high blood pressure, diabetes and weight problems, should be regularly cared for by a renal specialist.

Let me finally say something to our witnesses representing our Nation's medical schools and health care centers. It is the integrity of your medical schools, academic departments, faculties and residency programs that are at risk by this government take-over of medical education.

However, your written testimony shows that you have not yet found your voices in defending your schools and residency programs. As we debate these issues in the coming months, we must

hear from the Nation's medical school deans and faculty. If you do not defend your programs, neither will the Congress.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Bliley.

Mr. Rowland.

Mr. ROWLAND. Thank you, Mr. Chairman. Because community and migrant health centers are of such interest to me, I am really pleased that our hearing today will focus on this issue, and I commend the administration for including grants for community networks in its proposals.

I cannot stress enough the importance of community health center networks, which is why I introduced with my colleague, Congressman Mike Bilirakis, my H.R. 3573, the Community Health Improvement Act of 1993.

Many people are focused on overhauling our entire system. I believe we need to do something right now and address a problem that is getting worse every day, providing primary preventive care for Medicaid recipients who currently have difficulty getting doctors to see them on many occasions, and the uninsured and underinsured who wind up in emergency rooms for their health care on many occasions.

The legislation we have introduced will allow States and local communities to work together to develop networks to address the needs in their own communities. In order to have a successful health care program, we must start at the community level before we implement an entire unknown system nationwide.

We already know from our many examples how important this approach is. There are now more than 700 community health centers in our country that are providing care on a very timely basis, and I know of at least two in the district that I represent that are doing an outstanding job. Johnson County, Georgia has a community health center and it is a rural area, and Dougherty County, Georgia is an urban area which has a community health center that is doing extremely well.

This legislation will attempt to address some of the important issues we face in health care today, such as financing. The United States spends more than 14 percent of its Gross Domestic Product on health care. We don't need to spend more.

H.R. 3573 uses existing public and private dollars to provide better care on a local level. I believe that we can begin to implement reforms and less expensive ways instead of drastically changing the way our current health care delivery system is structured.

So I look forward to working with my fellow colleagues in the coming months on this very important issue and I yield back.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Rowland.

Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman.

Mr. Chairman, at the outset, it is just so very significant that all of the Congress know and all of America know that we all want to see a reformation of the health care system. There are problems out there. They have got to be addressed and somehow solved, and so I do add my commendations to others, to you and to the Presi-

dent for bringing this up and putting it on the front burner, and that is so very significant.

But, Mr. Chairman, we have basically just returned from a 2-month break, if we can call it a break, and many of us—I spent all of the two months at home and I have met with a lot of people and I find that the more that people become familiar with the Clinton health care plan, the more frightened they become. It is an unknown. It is a great unknown out there.

They are not really sure how it is going to affect them. They are concerned about it. Mr. Chairman, Dr. Rowland mentioned the community health center concept. That is one idea of how we can approach the accessibility problem.

There are certainly many other ways that it can be done, but there are ideas out there. There are alternatives out there and I think it is just critical that we remain open-minded and try to look at new ideas.

Mr. Chairman, a lot has been said about a so-called incremental approach, a lot of things can be done now. During my two-month period of time, in addition to hearing people talk about why they should have to give up their health care plan, I find that there are two hospitals in my area that would like to merge. I was told just yesterday that it has cost them over \$0.5 million already, working with the government trying to get permission to make sure that every I is dotted. One of the approaches of the President's plan, included in every other approach, is something to do with antitrust and changing the antitrust laws in order to allow this to take place so that we don't have to have an overlap of facilities and technology as we do all over the country. Of course that all adds to the expenses.

So, Mr. Chairman, I think it is just ridiculous. I think it is almost criminal that we take a look at this as an all or nothing type of an approach. I think there is a lot that we can do now that are consensus items, antitrust being one of them, insurance portability, malpractice reform, the streamlining of the system, all of these things that can be done now. Without your leadership, sir, I don't know that we are ever going to seriously approach that viewpoint, however, and so I plead with you to remain open-minded.

Let's listen to these witnesses. Let's take a look at some of these things that can be done now and we can all work together toward accessibility.

Thank you, sir.

Mr. WAXMAN. I thank you for those comments and I hope you will remain open-minded and listen to what we have to say as well, and then we have got to work together.

Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman. I normally, in the interest of time, don't make an opening statement. Yesterday's hearing was quite lengthy and we all were thankful for Mr. Bliley's enlightening clip from Canadian television. I think there is a little more to the story than he told us yesterday.

About a month ago in the New York Times there was a story also about the Canadian system that addressed some of the issues that Mr. Bliley talked about. One was that in a report from the Ontario Health Minister for a six-month period, 60,000 medical claims were

made on behalf of patients who held American driver's licenses. The total number of improper claims in Ontario in that period was 600,000 improper claims.

One doctor said, I would estimate that from 12 to 20 of my patients at any one time are ineligible Americans, and I am just one of 520 doctors in Windsor and one of 23,000 doctors in Ontario. So this whole myth about Canadians fleeing their health care system to get care in America is more myth than reality when, in fact, there are serious numbers of Americans going north and partaking illegally and fraudulently many times in the Canadian health care system.

The chairman of the Public Accounts Committee, Ontario legislature, said fraud is squandering our resources and that is one of the reasons they have had these end-of-year problems and their budgeting problems.

A couple of more comments. Once one Tory health spokesman in the Ontario legislature said Canada is an easy route for Americans. If they can find a health card, they have a pretty good chance of using that card undetected for as long as the party lasts and the party certainly won't be over tomorrow.

We hope it is a temporary phenomenon until President Clinton gets his own health care plan through. I bring that up because I think all of us are tiring of the—of corporate America's misinformation campaign about Canada's health care system.

Canada's health care system has weaknesses, surely, but the misinformation campaign from lobbyists and interest groups and people that want to discredit Canada for their own by and large greedy purposes, if you will, is just growing a little tiresome, and I think we should look at the strengths and the weaknesses of the Canadian plan.

We should think about the administrative costs. We should think about the access for preventive care and all that Canada does well, and not just focus on the myths and some horror stories that we all can find when we search any large system in another country.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you very much, Mr. Brown.

We are pleased to have with us Congressman Sharp who is a Member of our full committee, and I want to recognize him.

Mr. SHARP. Thank you very much. Mr. Chairman, I won't take any time. I know we have a lot of witnesses to hear this morning.

Thank you.

[The prepared statement of Hon. Mike Synar follows:]

STATEMENT OF HON. MIKE SYNAR

Today we are hearing testimony on some of the most difficult issues facing health care reform—how to reach the people who are the hard to reach, both in urban and rural areas. As one of the founders of The Rural Health Care Coalition, this is especially important to me and to the people in the State of Oklahoma. In Oklahoma alone there are 34 counties that have just 1 primary care physician for over 3,500 people, and 14 rural hospitals have closed since 1985.

Telemedicine is a relatively new field, but one whose importance cannot be underestimated. I am a strong believer in the wisdom of forging ahead in the expanding field of telecommunications. Telemedicine can bring brand-new technologies to underserved areas, and will give patients access to specialists' advice and services without having to travel to the nearest big city, or often times, even out of state just to have an x-ray read.

I am looking forward to hearing the testimony of a fellow Oklahoman, Dr. Garth Splinter, Director of Health Sciences Center at the University of Oklahoma, who will be able to tell us about some of the strides that have been made in Oklahoma in the area of telemedicine. Oklahoma has long been a pioneer in developing a telecommunications infrastructure to improve the quality of life for all Oklahomans. This commitment is evidenced by the significant amount of funding Oklahoma has already devoted to extending the Oklahoma Telemedicine Network to 38 additional rural hospitals in 1994.

While telemedicine is not the cure-all to the health care problems in rural communities, it is something that is rightfully addressed by the Health Security Act and is indeed necessary to improve the health and well-being of this country's rural residents.

Mr. WAXMAN. Thank you very much. Our first witness this morning is Dr. Philip R. Lee, the Assistant Secretary for Health in the Department of Health and Human Services. Dr. Lee has a distinguished career in public service having been appointed the first Assistant Secretary for Health by President Johnson in 1965 and most recently serving as the Chairman of the Physician Payment Review Commission.

Until his appointment last year, Dr. Lee was the Director of the Institute for Health Policy Studies at the University of California at San Francisco.

Dr. Lee, welcome back to our committee. I think this is the first time you been here in your new capacity. You have been called back to take on this job again, and we are all delighted that you are assuming these responsibilities.

We look forward to working with you on a whole range of issues. Your prepared statement will be in the record in full. We would like to ask, if you would, to try to limit the oral presentation to five minutes or thereabouts.

STATEMENT OF PHILIP R. LEE, ASSISTANT SECRETARY, PUBLIC HEALTH SERVICE

Mr. LEE. Thank you, Mr. Chairman, Mr. Bliley and Members of the subcommittee. I don't need to dwell on the issues that we are addressing this morning.

I do want to discuss two of the public health initiatives which are integral to the Health Security Act, H.R. 3600, the access initiative and the initiatives related to graduate medical education and the academic health centers.

In the testimony submitted for the record, I really describe and put the health—public health initiatives in perspective and why they are central to the proposed reforms. The Health Security Act has, I think, a little appreciated orientation which emphasizes not only prevention, but close working relationships between public health and personal medical care to achieve common health objectives.

In the access initiatives which are contained in title III, these are designed to assure that all Americans have access to the health services included in the comprehensive benefit package, no matter who they are or where they live.

The initiatives are included in H.R. 3600 because providing a health security card does not assure access for everyone. It is essential but not sufficient for many, for reasons of poverty, of language, geography or other factors. Therefore, they need additional help to remove these barriers to access.

There are six interrelated approaches to ensure access in title III. First, consider those that relate to the current safety net programs. These will all be continued. Community and migrant health centers, programs for the homeless, family planning, Ryan White, and maternal and child health programs will be maintained and strengthened. All of these providers will be designated essential community providers in the plan. They will receive continued funding.

There would be added funding for enabling services and as the health plans are implemented, all will receive payment from those plans for services provided that are in the benefit package.

Second, with respect to practitioner supply, the National Health Service Corps will be expanded from a field strength currently of about 1,600 to 5,300 by 1998 and 8,000 by the year 2005. We will also, in the initiative, increase funding for the development of training programs for generalists, primary care physicians, nurse practitioners, physician assistants, and others who could be providers of primary care.

The third element is the capacity expansion initiative. This is for the development of community-oriented practice networks designed to integrate federally funded providers with other providers in underserved areas, to bolster their ability to coordinate care, to negotiate effectively with plans, and to form, if they wish to, their own plans.

Using grants, loans and loan guarantees, the capacity expansion would provide for new practice sites and renovation of existing or conversion of existing sites in urban and rural areas. All providers included in the practice networks will receive designation as essential community providers.

The fourth element is outreach and enabling services—including transportation, translation, nurses or home visitors, and reaching out to those who need access to care and child care services, among others.

The fifth element is the mental health and substance abuse programs. These would be continued with additional funds to expand the enabling services in the transition until full benefits are provided in the plan.

They would continue the present range of services and would help to build the infrastructure between public programs and the new benefits in the plan.

The sixth element is a program for school age youth, including comprehensive health education (K through 12) in the schools and school-based health-related services in low income areas where youngsters are particularly at high risk.

This would include psychosocial counseling services, social support services to facilitate risk reduction and behavior change in young people who are exposing themselves to high risks in terms of their health. They would be linked with the plans so that a youngster coming to a school-based clinic would be referred to primary providers if they have got a medical problem that requires continuing care.

The goal of all of these access initiatives is to assure that services are available when needed and where needed and to help over-

come the barriers to access, whether these be language, culture, geography, or poverty.

Let me turn to the work force issues and the academic health centers. The academic health centers, of course, are among the essential institutions in this country in terms of basic and clinical research, in terms of health professions education, and in terms of a wide range of medical and health services.

The need for workforce policy changes relates first of all to access. We have geographic medical maldistribution. We do not have enough family practitioners who are the ones that principally practice in rural areas. We do not have enough nurse practitioners or physician assistants who could work with physicians in those areas.

Given an oversupply of medical subspecialists particularly, we are left with too few generalists so that access is not what it should be. The aggregate supply affects cost and the specialty maldistribution affects costs.

We also have a need to assure quality of care. The academic health centers play a major role. The trends in health care and the rapid growth of managed care plans, whether or not there is a policy change as proposed in the Health Security Act, will, we believe, adversely affect the academic health centers, because increasingly, those plans are unwilling to pay for the additional costs of patients referred to academic health centers.

They are unwilling to pay the additional costs of residency training in those centers, so that we will see, I think, these institutions severely impacted in the future by trends that are very well developed in areas like California, and rapidly developing in States like Oregon, Washington, New Mexico, and Minnesota. In some other States similar forces will be emerging because of the pressures of large employers to contain costs.

The pressures for the development of these managed care plans have come largely from the employers seeking to contain their expenditures for medical care and assure their workers adequate care. These health care reform proposals have to be examined in the context of those trends.

We are proposing three policies. One is the creation of a pool for the funding of graduate medical education. The second is a fund for graduate nurse education, and the third is a fund for the academic health centers. The fund for direct medical education would be allocated by a national council. The council would set goals in terms of numbers and types of physicians to be trained after medical school or osteopathic school graduation. That would of course be in consultation with those institutions and with the various specialty and sub-specialty bodies involved.

They would allocate positions as proposed in the legislation: 55 percent in primary care, including general medicine, general pediatrics, obstetrics and gynecology and family medicine, and 45 percent in all the other specialties, general surgery, radiology and the others.

There would be a gradual reduction in the total number of residency positions in the legislation. We do not specify a number. Others have proposed that that limit be set at 110 percent of U.S.

graduates. Currently there are about 135 percent of U.S. graduate positions available.

In other words, we graduate 17,000 osteopathic and allopathic students a year, there are 20,000 first-year residency positions. So there would be a gradual reduction as we propose, and that decision would be made by the council on a rolling basis as opposed to setting a goal at the outset. However, that approach has been proposed as well by Congressman Waxman, Senator Rockefeller and others.

The fund for graduate nurse education would function in a similar manner as the funds for medical education, funding those specialty training programs for clinical nurse specialists, including those in primary care who are, we think, an essential component of the system.

And finally, the fund for the academic health centers would help to level the playing field. The costs are higher in those institutions. We want patients who need to be referred to cover those additional costs.

The health plans would be required to contract with the academic health centers for appropriate referrals. Patients who undergo clinical trials would have to be in approved trials in those institutions. These funds would help cover those additional costs.

Those are the basic elements. I believe that this is an historic opportunity for the Congress and the administration to craft a health plan and—both in terms of financing and the other provisions that will meet the needs of the American people.

I am an enthusiastic supporter of the plan that we have submitted. I believe that it will meet the needs that have been identified in a very constructive way and that it will improve access, assure containment of costs, will assure security for everyone in terms of their health insurance, and equally important, contribute significantly to improving the health status of the American people.

Thank you, very much.

Mr. WAXMAN. Thank you very much, Dr. Lee.

[Testimony resumes on p. 290.]

[The prepared statement of Dr. Lee follows:]

STATEMENT OF

PHILIP R. LEE, M.D.

ASSISTANT SECRETARY FOR HEALTH

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Mr. Chairman, Mr. Bliley and members of the Subcommittee, I welcome this opportunity to discuss two of the public health initiatives integral to the President's Health Security Act. First, the access initiative for rural and urban medically underserved areas. And, second, the graduate medical education and academic health center provisions. I look forward to testifying on other public health initiatives at subsequent hearings.

However, before I turn to the specific provisions of the access initiative, it is important to take a moment to put the entire public health initiative in perspective. In recent years, as the private health insurance system failed more and more working Americans, State, and local public health agencies became increasingly involved in providing personal medical care and mental health services to the poor and uninsured.

In an environment of limited resources, this shift in public health spending toward personal medical care was at the expense of public health programs designed to keep communities healthy. This steady erosion of funds led the Institute of Medicine in 1989 to declare the public health system to be "in disarray" and a "threat to the health of the public." The American Public Health Association, in its recent report "Public Health in Reformed Health Care System: A Vision for the Future", reiterated these problems. We have confirmed these reports in our own analyses during the past year.

We now have an historic opportunity to improve the health of the American people. Under the Health Security Act, we will do far more than just treat people when they are sick. We will achieve the fundamental goals of our nation's health promotion and disease prevention agenda:

- Increase the span of healthy life for Americans and
- reduce health disparities among Americans.

If we reform the personal care system as the President has proposed, the public health system will no longer need to provide covered personal health care services to indigent and uninsured populations. Instead, public health agencies can turn their resources and expertise to their original role of protecting the health of communities and removing barriers to medical care.

An important, but not well known, element of the President's plan is the re-invention of our public health system. The Health Security Act calls for an increased investment in public health. If we follow this course, people will suffer fewer illnesses and injuries, and the government, health care providers, businesses and individuals will avoid considerable health care costs.

THE NEW HEALTH-ORIENTED FRAMEWORK OF REFORM

The President's plan has a new health-oriented approach that emphasizes prevention, accountability and a close working relationship between the personal care and public health systems. Central to this approach is a restructuring of the personal health care system, enabling it -- for the first time -- to focus its energies on keeping people healthy.

For the first time, all Americans will have health insurance with a comprehensive benefits package that includes clinical preventive services without deductibles or copayments. Regional alliances and health plans will be responsible for making sure that their populations have access to covered services. Report cards will hold them accountable. A health plan's performance and the overall health status of its membership will be available for review by members of the plan and members of competing plans.

Report cards along with the financing and payment system will reward alliances and health plans for keeping their populations well. Health plans will receive a fixed annual premium to cover total patient care. To the extent their enrollees are kept healthy, both health care costs paid by the plan and premiums paid by individuals and employers will be lower.

To achieve a system that is accountable for advancing people's health, the President's plan details an electronic highway of data with uniform health data standards and shared responsibilities. Three specific but highly interrelated types of data are required:

- data to support the administration and operations of the health care system;
- data to monitor the implementation of health care reform and assess its impact on the population; and
- data to support core public health functions under health care reform.

Mr. Chairman, these changes in the personal health care system will make it possible to refocus the public health system on protecting and promoting the health of our communities. By working closely with alliances and health plans, public health agencies can be far more effective in achieving community-wide improvements in health. For example, they can work through alliances and health plans to inform and educate individual patients and providers. And they can reinforce the efforts of alliances and health plans by protecting communities against environmental hazards, identifying and controlling community

outbreaks of infectious diseases, and instituting community-wide education programs.

Reforming the public health system is not supplemental to health care reform. It is an integral part of achieving the goals of reform. The Public Health Initiative contained in Title III of the Health Security Act is the means the President proposes to strengthen and refocus the Nation's public health system. The success of these programs will be measured by how well health security is provided for all Americans and how well health disparities among Americans are reduced or eliminated. They will also play a vital role in determining the extent to which we will be able to contain accelerating health care costs.

The Access Initiative

Now I will turn specifically to the Access Initiative for rural and urban medically underserved areas. Special initiatives contained in Title III will assure that all Americans have access to the health services included in the comprehensive benefits package and have a genuine choice of culturally sensitive providers and health plans -- no matter who they are or where they live.

The Health Security Act uses six interrelated approaches to expand capacity in underserved areas and to remove barriers that isolated, culturally-diverse, or hard-to-reach populations face in obtaining access to care.

● **Current Safety-Net Programs.**

First, support service portions of current safety-net programs such as community and migrant health centers, programs for the homeless, family planning, Ryan White, and maternal and child health will be maintained and strengthened. Providers funded under these programs will receive automatic designation as essential community providers. This will guarantee them payment for covered services from all health plans. Equally important, it will assure that vulnerable populations have continuing access to practitioners experienced in meeting their special needs, regardless of which health plan they choose to enroll in.

● **Practitioner Supply.**

The supply of practitioners in underserved areas will be increased through a five-fold expansion of the National Health Service Corps from its current field strength of 1,600, to 5,300 in 1998, and 8,000 serving over 12 million people by 2005. Residency training will be redirected to increase the ratio of primary care physicians to specialist physicians and by supporting the training of primary care physicians, physician

assistants, and advanced practice nurses. Special programs to increase the representation of minorities among health professionals will help to overcome access barriers that stem from cultural gaps.

● **Capacity Expansion.** Capacity expansion in inner-city and rural areas will be actively supported by expanding the successful community and migrant health center program and through a new competitive grant and loan program for the development of community-oriented practice networks and health plans. Capacity expansion of the community and migrant health center program will provide services to an additional 2 million individuals.

The new program is designed to integrate federally funded providers with other providers in underserved areas, bolstering their ability to coordinate care, negotiate effectively with health plans, and form their own health plans. The creation of new practice sites and renovation and conversion of existing practice sites, including public and rural hospitals will build the infrastructure in underserved areas and improve the practice environment for 3,800 practitioners working in community and migrant health centers and other existing sites. In addition, it will improve access to specialty care in urban and rural underserved areas and will be improved by using information and telecommunications to link with each other and with regional and academic medical centers.

Grants and loans will be made to groups of providers working in medically underserved areas or caring for underserved populations. In making awards, preference will be given to groups that include the maximum number of different types of federally funded providers and that link these providers with those not supported by public funds. All providers included in the community practice networks will receive automatic designation as essential community providers.

● **Outreach/Enabling Services.** The Access Initiative also incorporates a new competitive grant program that will expand federal support for enabling services, such as transportation, translation, child-care, and outreach.

These grants will assure that isolated, culturally-diverse, hard-to-reach persons not served by other programs get the supplemental services they need to obtain access to medical care. They will also help individuals who have been denied access to the current medical care system shift their care patterns away from emergency rooms and receive earlier and more appropriate primary care services.

Awards in this program will be made to community practice networks, community health plans, and other public and private not-for-profit organizations (such as community health centers) with experience and expertise in providing outreach and enabling services for underserved populations. These grants will supplement support for enabling services provided through existing Public Health Service programs.

● **Mental Health and Substance Abuse Initiatives.** The Health Security Act also includes new funds to assure that low-income, hard-to-reach individuals know about and take advantage of the expanded mental health and substance abuse treatment benefits included in the comprehensive benefits package. Further, in partnership with the States, we will continue to fund benefits for low income populations that are more comprehensive than Health Security benefits until the guaranteed benefit package expands to include a full range of services for everyone.

Working through the existing Community Mental Health Services and the Substance Abuse Prevention and Treatment formula grants, additional funds will support enabling services -- community and patient outreach, transportation, translation, education -- for 2.5 million low-income individuals and other vulnerable groups (such as the homeless, dually-diagnosed, or severely mentally ill). In addition, they will build up the currently inadequate infrastructure for delivering mental health and substance abuse services in communities and facilitate integrating these services within the broader health care system.

● **School-Age Youth.** Finally, the Access Initiative incorporates two new programs to reach out to one of our Nation's most vulnerable groups -- school-age youth and adolescents. The Comprehensive School Health Education initiative will establish a national framework within which States can create school health education programs that improve the health and well being of students, grades K through 12, by addressing locally relevant priorities and reducing behavior patterns associated with preventable morbidity and mortality. This program will be targeted to areas with high needs, including poverty, births to adolescents, and sexually-transmitted diseases among school-aged youth.

The School-Related Services program will support the provision of health services -- including psychosocial services and counseling in disease prevention, health promotion, and individualized risk behavior -- in school-based or school-linked sites. It will provide up to 3.2 million children in over 3,500 schools with health and psychosocial services in places where they spend most of their time. Grants will be made to states for the development and implementation of projects targeted at high-risk youth ages

10-19 in high poverty areas. In states that do not take this initiative, grants will be available to local community-partnerships including public schools, experienced providers, and community organizations.

Why use a Multifaceted Approach to Assuring Access?

The President has developed a comprehensive strategy to achieve real access to medical care for all Americans. Under the current system, our challenge is to find and fund providers to care for indigent, uninsured populations. Under the Health Security Act, we have the opportunity to look beyond financing and to use the tools and resources of public health to build systems of care that will reach population groups that have not been effectively included in the existing health delivery system. It is critical, particularly in reaching populations that are isolated by poverty, language or culture, to create provider networks that are responsive and attuned to their special needs and concerns. Providing a real choice for these individuals and families is a critical element of the President's plan.

Safety-net providers should thrive under the new programs. The Health Security Act authorizes substantial new funds over fiscal years 1995 through 2000 to expand enabling services and to assure access to the full range of benefits provided under the Health Security Act. In addition to this targeted funding, a substantial portion of the resources from other programs will also target safety-net providers.

-- Capacity expansion programs will support the building of new facilities (such as community health centers and family planning clinics), capital improvements of existing facilities, and information systems to link centers with other providers and institutions.

-- An expanded National Health Service Corps and other workforce initiatives will increase the supply of practitioners from which safety-net providers can draw.

-- The new enabling services program will provide funds for translation, transportation, child-care, and outreach services.

-- The essential community provider designation program will assure safety-net providers payment for covered services from all health plans.

I wish to emphasize that federally funded providers, such as community and migrant health centers, will continue to get paid in full for all of their services, even though the source of that payment changes. Payment for covered services will come from

health plans instead of the federal government. Payment for enabling services will come from current PHS programs as well as the new enabling services program.

Funding will be more effective under the new system because programs in the Access Initiative have been designed to complement and reinforce each other. The National Health Service Corps will focus on the most difficult to reach underserved communities, while other access programs will improve the practice environment in underserved areas, making many of them more attractive to physicians and other health professionals. The need for enabling services will decrease over time as new practice sites lessen the need for transportation and as a more robust supply of minority health professionals overcomes language barriers and other cultural gaps.

HEALTH CARE WORKFORCE AND ACADEMIC HEALTH CENTER PROPOSALS

I would like to turn now to two additional components of the Health Security Act that have been a major concern of the Members of this Committee for many years, the policies regarding the health care workforce and academic health centers.

It was this Committee that reviewed physician specialty mix and reported a plan to improve training patterns in 1974. I know that you have maintained that interest in the intervening years as you have considered and refined the many primary care and other programs in Title VII.

Workforce and academic health center policies are critical to achieving the important health care reform goals of security, savings, and quality.

- **Security and the Workforce.** An adequate supply of appropriate providers is essential to the principle of security -- of assuring people they will have access to medically necessary and appropriate care when they need it.

Our workforce today is maldistributed by both geographic area and by specialty. Many urban and rural areas have too few primary care physicians and some have no providers at all except the nearest emergency room.

Despite these shortages, the skills of nurse practitioners, nurse midwives and other types of non-physician primary care providers are under-utilized.

The under-representation of minorities among the health professions is a severe barrier to care for many underserved populations. Increasing diversity in the health professions

is essential to assure availability of culturally sensitive care as well as to provide a genuine equality of opportunity for minorities to pursue health careers.

● **Savings and the Workforce.** The problem today is that we have too many physicians practicing in specialties and subspecialties other than primary care. Graduate medical education (GME) has been driven by economic incentives in the payment system, rather than by policies directed to meeting the health care needs of the American people. The long-term absence of national policies regarding physician training has led to a specialty-dominated system which generates unnecessary health care spending.

The current imbalance has been encouraged by federal policies, and it will not be reversed without explicit changes in incentives. Beginning in 1963, the Federal government initiated policies to deal with what was widely perceived to be a physician shortage. At first, grants and loans were provided to expand facilities. Then, direct Federal support was provided for medical education. These policies succeeded in increasing the number of physicians.

Early in this period, there were roughly 300,000 active physicians or about 150 per hundred thousand population. Currently, there are almost 600,000 active physicians in practice and we have a ratio of 230 per hundred thousand population. At current training levels, by the year 2020, there will be 875,000 active physicians, or a ratio of over 300 physicians per hundred thousand population.

Despite the rapid growth in physician supply, we continue to add to our pool of physicians many graduates of international medical schools who enter residency training in the U.S. One-fifth of all practitioners are now international medical graduates and approximately one-fourth of all first year residents are graduates of schools abroad. This growth has been supported by Federal policies initiated in the 1960's and 1970's to grant physicians preferred immigration status. The creation of large numbers of residency positions in hospitals providing care for low income populations has provided the employment base to absorb these graduates.

In addition to excess numbers, physicians are badly distributed by specialty. More than two-thirds of physicians in the United States are specialists, and under current policy this specialty mix will continue into the next century. Today, over 65 percent of new physicians are

trained in the non-primary care specialties and sub-specialties.

Physician overspecialization have severe cost and quality implications. The average cost of an additional physician in practice has been estimated at between \$500,000 and \$1.0 million a year -- three-quarters of which is related to physician-generated expenses. Because specialists generate far more tests and procedures than primary care physicians, an over-supply of non-primary care specialists drives up costs without improving patient outcomes. It would be very difficult to create payment and utilization controls to overcome practice patterns instilled through many years of training. We clearly need to slow long-term growth.

- **Quality and Academic Health Centers.** The high quality of health care in the United States is directly associated with the special role and mission of our nation's academic health centers (AHCs).

AHCs and their affiliated teaching hospitals educate most of the health care providers and biomedical researchers trained in the U.S. They foster the rigorous pursuit of biomedical and health systems research which have made the U.S. the leader in technological and therapeutic discovery.

Academic-centers provide sophisticated and scientifically-advanced care for a wide range of patients and maintain critical services such as transplant centers, burn units, genetic laboratories, and other unique services not available in community hospitals.

Maintaining these centers of excellence entails special costs that are now paid through direct payments and indirectly through reimbursement for services. As health care reform creates changes in reimbursement systems, we must assure that it does not diminish access to the specialized care offered by AHCs, or slow new advances in medicine, or undermine the training of physicians and other health professionals.

PROPOSED POLICIES FOR WORKFORCE AND ACADEMIC HEALTH CENTERS

Title III, Subtitles A and B of the President's Health Security Act will provide strong new national policies to improve the workforce and support the special missions of academic health centers. The instruments to accomplish these goals are three new funding pools that will subsidize physician and nurse training and support for academic medical centers. The training subsidies

will produce a workforce distribution better calibrated to service needs, and to the provision of cost-effective care. The subsidies to academic health centers will protect their core capacity for excellence in training, research, and the provision of highly specialized services.

The first would finance the direct costs of graduate physician training. The second would fund the training of nurse practitioners and graduate level nurses. The third pool would support the unique mission of academic health centers in training health professionals, conducting research, and providing specialized services and caring for patients with complex illnesses.

These pools are funded from projected Medicare payments for graduate medical education and indirect medical education and additional payments from private insurance premiums and other funds. The three pools would together total almost \$10 billion when fully implemented in 1999.

This approach is fairer than the current system because it spreads training costs for the next generation of health professionals, and support of research and special service activities of academic centers across all health care plans. They also help guarantee that academic centers can compete with other providers for patients and, thus, continue to play their important role in our health care system.

Health workforce reform policies

In addition to assuring adequate support for graduate physician training, the national graduate medical education pool provides a mechanism for making decisions with respect to the numbers and types of new physicians that we will need in the future. The goal is to achieve a better fit between the health care needs of the American people and the supply and distribution of providers.

Projecting workforce requirements by type of practice and geographic area in a dynamic society such as ours must be done with care, excellent information, and close consultation with all affected parties. The President's plan proposes that decisions regarding the number and specialty mix of new physicians be made by a National Council on Graduate Medical Education, with members of this council representing all interests affected -- consumers, educators, practitioners, the alliances and the plans, and others.

Through a deliberative process which considers the recommendations of the professional community, the Council would establish national goals for the number and type of new physicians to be trained, beginning with academic year 1998-99.

Once national goals are set, the Council would allocate available positions among individual training programs. Funds from the graduate medical education pool would only be paid to institutions for approved training positions. The allocation of positions will increase the ratio of generalists to specialists. The goal would be for 55 percent of residents entering residency training in academic year 1998 to subsequently enter practice in family medicine, general internal medicine, general pediatrics, or obstetrics and gynecology.

In setting targets and making allocations, the Council would consider the extent of need for additional practitioners in each specialty, the historical training patterns, the extent to which programs draw trainees from diverse populations, and the recommendations of physician and consumer organizations.

The program also has the goal of gradually reducing the number of first year residency training positions from the current level of 135 percent of the number of graduates from U.S. allopathic and osteopathic medical schools, to a number more closely approximating the number of U.S. graduates. Last year, for example there were about 24,000 first year residents in training and about 17,300 graduates from U.S. allopathic and osteopathic medical schools. The plan does not set an exact numerical target for reductions, but leaves flexibility to determine percentage reductions.

The funds from the graduate medical education pool will be paid to training programs which may be sponsored by academic health centers, medical schools, clinical departments, hospitals, clinics, HMOs, or multispecialty groups. The broad range of eligible organizations, will encourage increased training in ambulatory settings.

While specialty changes and the downsizing of the resident workforce would be phased-in over the next decade, hospitals with large specialty training programs will be affected early and will need to adapt. Although the primary goal of residency training is education, residents also provide considerable patient care at a low cost. To facilitate adjustments in hospitals which end up training fewer residents overall, the Act provides transition payments for a four year period.

Graduate nurse education

A second \$200 million national pool would be established to support graduate nurse training, and is configured in a manner similar to the physician training program. The pool will support

advanced nurse education programs, including nurse practitioners, nurse midwives, nurse anesthetists, and clinical nurse specialists requiring advanced training.

A National Council would establish targets for the specialty mix of nurses and allocate positions to individual training programs. Nurses trained would meet immediate needs for more primary care providers, and provide a pool of nurse specialists able to provide much of the care previously provided by hospital residents, as the resident pool is downsized.

Related workforce programs

An additional \$400 million per year is authorized for other workforce programs in the Public Health Service. To expand support for existing primary care authorities which assist development of generalist residency training programs, training in rural and underserved areas, and other related programs which foster an interdisciplinary, primary care workforce.

In addition, funds would expand opportunities for under-represented minorities, so we can move more aggressively to the goal of diversity in the workforce.

Finally, there would be additional support for nursing at the undergraduate level, for special training in school health, for development of new training programs for nurse practitioners and physician assistants.

Academic health center policies

AHCs and their affiliated teaching hospitals are higher-cost providers than community hospitals. Private insurers now pay roughly 25 percent more for treatment in academic health centers than they do for similar services in community hospitals.

If AHCs and teaching hospitals are to continue to play their critical role under the more competitive health care system envisioned by the President's Health Security Act plan, two steps are necessary.

First, there will need to be special financial support to offset costs in AHCs which are inherently higher, a legitimate product of training physicians and other health professionals, conducting clinical trials, research and technology development, and building and maintaining the capacity to provide specialized care.

Second, even with a national pool to subsidize the special missions of academic centers, AHCs will have to become more price competitive relative to other patient care institutions by revamping their organization and operations and so improving their efficiency and productivity.

The Health Security Act, as previously discussed, establishes two pools to support direct graduate medical education and graduate nurse training. These two pools, totalling \$6.0 billion in 1999, are very important to the future of academic centers and teaching hospitals.

The third pool, for academic health centers and teaching hospitals is funded at \$3.7 billion in 1999. This pool is especially important as it provides support for the less well specified but never the less real additional costs of these institutions.

Funds from this pool will be allocated to academic health centers and teaching hospitals based on a formula which takes into account an institution's intern and resident-to-bed ratio and total (all-payer) inpatient and outpatient revenues.

This approach changes the current Medicare indirect medical education (IME) payment formula, by taking into account the impact of universal health insurance coverage. As universal health insurance becomes a reality, Medicare will contribute to the AHC pool at a rate to reflect the added costs of residency programs, based on the intern/resident-to-bed ratio. Moreover, MCR DSH payments will be retargetted to vulnerable populations.

In addition to receiving explicit payments for non-patient care services, AHCs will also continue to treat patients with rare and complex conditions that need specialized care.

To ensure that patients are referred to AHCs for specialty services that are best provided in such centers, alliances and health plans will be required to make specific arrangements with AHCs.

- **Contracts.** In order to guarantee that patients will have access to the specialized services offered by AHC hospitals, health plans will be required to contract with an AHC for referral and treatment of patients with rare diseases or unusually severe conditions, and for providing other specialized health care.
- **Clinical trials.** Routine care during investigational treatment is a covered service. Alliances will provide consumers information on availability of clinical trials to ensure appropriate access.
- **Quality assurance.** Alliances and the National Health Board will provide quality assurance and appeal mechanisms to assure that health plans are appropriately referring members to special hospitals.

I thank members of the Subcommittee for this opportunity to discuss two important features of the President's Health Security Act -- the access initiative for rural and urban medically underserved areas and the graduate medical education and academic health center provisions. I will be pleased to answer any questions you may have now.

Mr. WAXMAN. As we look at legislation that is going to provide health security to all Americans, the ability to get care when people need it, we obviously have to have people to give that care, and the administration is looking at two areas where we are going to provide more care. One is to change from the doctors who are in specialties and subspecialties and have more of them go into the primary care services so that we can provide preventive and early intervention care for people, and maybe even avoid some of the costly expensive care later on.

But we are also going to need some of the functions regardless of any reform of the health care system and that is to have the community health centers, migrant health centers, the family planning clinics, the Ryan White AIDS clinics, the school-based clinics to be there for people right in the places where they will have the best access to those clinics.

The administration's bill purports to want to provide more money for that infrastructure of clinics and Public Health Services, yet while there is money authorized to do that, there is no money that will not have to be appropriated, and when we have these caps on spending and we have an authorization and the cap on spending is to spend no more in future years than we are spending now, in order to provide those additional funds, we are going to have to take them from other public health programs.

Are we promising to do things that we are not going to be able to do because we won't be able to get the appropriations to do it?

Mr. LEE. Mr. Chairman, there is no one more sensitive to that issue than myself. The administration is absolutely committed to working with the Congress, to work with you, work with the full committee chairman, and work with the others who are in key positions to determine what that source of assured funding will be.

But the administration is committed to that. We will work with you to identify that, and I hope we will do it promptly. Clearly that needs to be resolved.

Mr. WAXMAN. Well, that means we are going to have to change the bill because—

Mr. LEE. Yes, sir.

Mr. WAXMAN. Because right now they are under those caps which would mean we are promising something that we really can't deliver.

Mr. LEE. That is absolutely correct.

Mr. WAXMAN. You indicate what I think all of us know, there are too many physicians that have gone into specialties and subspecialties and not into primary care. Part of that is the way graduate medical education is handled.

There is a clear inducement to have, from the medical school and teaching hospital point of view, more people go into these specialties than to go into primary care. That of course not only means that we don't have enough primary care physicians available, but it means that we spend more money in health care costs because these specialists are more expensive and they will drive up the costs with more care that they think needs to be done.

I gather in your bill you would establish a national council to reduce the overall number of approved residency training positions

and increase the number of slots in the primary care disciplines to at least 55 percent of the total.

That sounds like a worthwhile goal, but how would you achieve it?

Mr. LEE. Well, first of all, Mr. Chairman, the council and the Congress will decide how quickly that needs to be done. In the bill, we hope to achieve that by 1998. In discussions with medical schools, with teaching hospital people, and with people in training programs, some people feel that we can't achieve the goal that quickly, even though they agree with the overall goal.

So that there needs to be a review of that by the Congress and a decision made as to when the goal should be achieved. We think that is the right goal, and it may be that it will take a little bit longer.

The council, in consultation with all of the people involved in training programs around the country (the academic health centers, the medical schools, the teaching hospitals, the training programs that are independent of those). First of all, they would set the goal by broad specialty, obstetrics and gynecology, family practice, general internal medicine, general pediatrics and other specialties, and then allocate the separate graduate medical education funds, to the approved programs.

No program would be funded that wasn't approved through the residency review committee, through the traditional reviews of those programs for quality. So that that process would be done. Then the mechanism for deciding—let's say, which residency program in cardiology might be approved, two things would be the principal determinants of that. One is the quality of the programs and the second is the historical patterns of those training programs. It is not the intention to disrupt dramatically the graduate training programs of this country, which we think are absolutely in the main very high quality.

There would be a rigorous review; so it would be a gradual process; and the decisions that would be made would be based on consultation with the specialties affected so that the best programs continue to be supported.

Mr. WAXMAN. Despite the fact that you want to have a transition and you want to have a consultive process, the American Association of Medical Colleges is critical of your proposal because they think the transition is too quick and they think there ought to be market forces that would produce these changes, whether we enact health care reform or not.

Certainly those market forces are taking some play now, taking some role in giving more of a thrust for the need for primary care doctors as opposed to specialists and subspecialists. They recommend that we have at least another eight years for the transition.

How do you react to that?

Mr. LEE. Well, two things. First of all, I was in favor of that idea myself until I had a lot of discussion with people and—including some economists who are big proponents of market forces. And I was convinced that the forces are too strong currently to produce the kind of results that we need within a reasonable period of time. So that I felt that we did have to go to this approach.

It may well be that we could sunset those provisions in 10 years when I think the market forces in fact will be working effectively with respect to graduate medical education. But, in the interim, it is my view after that careful set of discussions, that the market forces will not be sufficient.

Second, I go back to the mid-1970's. In 1975, we had these same discussions before this committee. It was agreed that we would have a goal about primary care. I think 50 percent was the goal, and we simply did not put any mechanism in for controlling the process at all. It was a voluntary process. Looking at the results in the last 20 years, we have gone progressively in the other direction, so that what we felt was a reasonable policy in the mid-1970s, since the mid-1980s, has proven not to have been, at least in terms of the national interest, the best approach. So I don't think market forces in the short term are the answer.

I do think this approach is a preferable approach.

Mr. WAXMAN. Thank you, very much.

Mr. Bliley.

Mr. BLILEY. Thank you, Mr. Chairman.

Dr. Lee, it is well-known that our Nation's elite medical schools, such as Harvard and Johns Hopkins produce very few primary care physicians, these medical schools which have the best and the brightest students and faculties who work on the full front of medical knowledge and discovery.

Do you really intend that our Nation's elite medical schools totally transform their residency programs to shift to primary care?

Mr. LEE. No, sir. Let me just say that I think that the University of California, San Francisco, is also among the best and the brightest. I served there as chancellor and as a member of the faculty for the last 25 years.

In fact, our graduates—at UCSF we are one of the most research intensive medical schools in the United States. Half of our medical students end up in primary care specialties. There is something different that we do at the University and that the Universities of Washington and Minnesota do, which are also first-rate medical schools. We are able in those public institutions to achieve a higher level of generalists and our students match, I would say, student-for-student with Harvard or Johns Hopkins or any of the best students in the country in terms of residencies.

It is not our intention to transform Harvard or those other teaching hospitals or Johns Hopkins or the other institutions in the country. Let me just give you an example of what we are planning at the University of San Francisco. Among other things, we will develop primary care residency training programs in the San Joaquin Valley, in Fresno, working with migrant health centers, a community hospital, a public hospital, and the physicians in the region will develop a regional training program for primary care physicians.

Different schools will take different approaches. But we certainly, if you look at the quality of the training programs, we want to support the best training programs in the country as we shift more towards generalist training and away from the, what I consider to be an excess number of medical subspecialists. However, it is not the

intention to in any way reduce the quality of those training programs.

I would just make one other comment about the role of the specialist in care for patients with chronic illness. In your opening statement, I think, you noted the diabetes complications and controls trial.

When I asked the chairman of that trial who was the most important person on the team taking care of those diabetic patients when they dramatically reduced the complications by strict control of blood sugar, he said (and this was a physician), the nurse educator. It does take a team approach.

The specialists, the endocrinologists must be involved in the care of those patients. We must have a system that assures appropriate referral, but on the day-to-day management that we think it can best be done appropriately by the generalist in consultation with those subspecialists.

In the plan the development of integrated organized delivery systems will not only permit that, but will foster that kind of team approach to care.

Mr. BLILEY. You mentioned a number of schools and that—and they are doing this on their own without government mandate. Why then is it not for the government to mandate it?

Mr. LEE. Well, in California the state legislature passed a bill that said to the University of California: you have to have 50 percent of your graduates in primary care. Now, UCSF happens to be doing that. Some of the other campuses were not.

The governor vetoed the bill. There was an agreement between the university and the legislature that the university would work to achieve those goals, so they are developing a plan to achieve those goals.

In Minnesota, it is my understanding that the State legislature directly funds the department of family medicine at the University of Minnesota. So State legislatures have, in fact, intervened in various ways to achieve these objectives.

I think the powerful forces at work in the marketplace—will underfund graduate medical education. So we do need this separate fund to assure the funding of those residents. Once you know you have to have a separate fund, it seems to me you need a system to allocate those funds with accountability and that is the reason for that national council being proposed.

Mr. BLILEY. You stated in your testimony that one-fifth of all practitioners are now international graduates and approximately one-fourth of all first-year residents are foreign graduates.

Rather than limiting the professional choices of American graduates, why don't you—we limit the number of residencies for international graduates?

Mr. LEE. The proposals that have been to reduce the number of residency positions. If you reduce the number, let's say, to 110 percent of U.S. graduates, that would provide opportunities for graduates from non-U.S. medical schools, now based in the United States, to compete for those residencies.

As a matter of fact, they could compete for any of the residencies and, if they were more qualified, there is nothing in our proposal that would exclude a graduate of a foreign medical school from ap-

plying and winning a residency, but if the number gets reduced say to 110 percent, that would be, I think, the way to achieve that objective without—more change in the current patterns of residency training.

Mr. BLILEY. Thank you, Mr. Chairman.

Mr. WAXMAN. Mr. Rowland.

Mr. ROWLAND. Thank you, Mr. Chairman. Dr. Lee, you were talking about graduate medical education. I didn't hear you mention the Department of Veterans Affairs. As you know, there are 127 medical centers that are affiliated with 104 medical schools in our country and, in fact, under these arrangements, the VA supports 8,600 residency positions annually, funding salaries and benefits for these residents while they are rotating through the VA hospital, and the Health Security Act Title III calls for establishment of a national system to govern the number of allocation of postgraduate training positions for physicians, but the act is solid on the VA's role in graduate medical education and it would establish a system that poses a substantial risk, I believe, of reducing disproportionately the number of resident positions that the VA now has.

The VA has an appropriation already for residency slots, so would you address the—address the role that the VA would continue to play in graduate medical education?

Mr. LEE. The VA of course has played a very, very key role since the Second World War in the development of really the system of graduate medical education in the United States. Virtually all those programs are affiliated with medical schools. So that as an academic health center or medical school and the teaching hospitals develop their plans for residency programs, the VA is intimately involved in those discussions and decisions.

My view is those residencies would continue. There might be some shift in the specialty—sub-specialty mix or the generalist sub-specialty mix, but I believe the VA would continue to be intimately involved.

I don't think there would be very much disruption, because they are so closely linked to medical schools and the development of their residency programs, and about 60 percent of the residencies are closely integrated.

For example, again, at UCSF our residents rotate through Martin Long hospital, San Francisco General, which is the public hospital, and the VA and that is a unified program and I think that is the pattern in many of the schools and I think that would continue.

If there is a non-affiliated program, we are proposing it calls for the direct funding of those training programs. So they would be eligible and they would be included, and they would be, I presume, quality programs so they would be approved programs even though the dollars then would in fact come from VA appropriations for those residents when they are in the VA hospital.

Mr. ROWLAND. The act would place downsizing decisions I believe in the hands of an HHS established entity which has no mandate to give any priority to the needs of the VA health care system and I just want to be sure that the VA health care system will continue

to be involved, and you have indicated that in the statement that you have just made, in the residency programs.

I got part of my training at a VA—and I suspect you did too when you came through, but—

Mr. LEE. No. VA has been such an important part of the whole graduate medical education. I don't think there is any suggestion in our proposals as introduced that would diminish the role of the VA in graduate medical education.

I certainly would want to make that abundantly clear.

Mr. ROWLAND. That was silent on the VA so I just wanted to be sure that—with the understanding that the VA would still be included.

Let me ask you this: About the concept of community health centers, a network of community health centers. Of course it is mentioned in the President's plan, but there are no details given about just how that would work, and as I said in my opening statement, we have introduced legislation that would spell out in some detail how community health centers would work.

What is your feeling about the possibility of community health centers and migrant health centers being able to provide acute outpatient care for many of the people now who do not have access to care, people who are uninsured and underinsured?

Mr. LEE. When everyone is insured, certainly there is going to be an increased demand for ambulatory care. Instead of patients going to hospital emergency rooms and then being admitted and going to the doctor or the outpatient clinic late in the course of their illness, they will be able to go early. So, I think there will be an increased demand immediately on those institutions for care.

We will continue the safety net Federal funding directly. We will expand through both the enabling grants to expand the outreach, but also the capacity expansion, the community health centers, and the migrant health centers, we would think, would serve as leadership institutions, in the development of those community-based networks. They have had the experience.

We really see them as one of the primary beneficiaries in a sense of the access initiative because they have served those populations that this initiative is designed to serve.

They wouldn't be the exclusive ones, but they would be significant leaders in the development of those programs and would significantly benefit from the provisions of the capacity expansion initiative in the plan. The benefit package with expanded preventive services again gives a major leadership role for the community and migrant health centers.

Mr. WAXMAN. Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman.

Dr. Lee, what was your sub-specialty out of medical school?

Mr. LEE. I was an internist, and I, although I didn't take sub-specialty boards in rheumatology, I had additional training in rheumatology, and when I practiced at the Palo Alto clinic, I did general medicine and was a consultant for the other physicians for patients who had serious problems with rheumatoid arthritis or other problems with arthritis.

Mr. BILIRAKIS. Doctor, I commend you for that, but if you can project yourself back to those days, not that long ago, I suppose,

but if you can project yourself back to those days, would you have been happy if big brother, if the government had basically dictated to you what specialty you could or could not go into, whether they had said you go into rheumatoid—a rheumatoid arthritis field?

Mr. LEE. If the circumstances were what they are today, I would say yes. My own view is that, as an individual physician, we are trained largely at public expense as medical students and residents. We have an obligation as physicians to serve the community.

If there is an oversupply of physicians in a particular sub-specialty, I don't see why the taxpayers, the people who buy health insurance premiums, should pay for a physician to get sub-specialty training in a field where there is already more than enough doctors in that field.

Mr. BILIRAKIS. Would you have been—if circumstances—I agree with you, circumstances were different then, but if they had been the same, would you, at your age, and wanting to do what you wanted to do, have been objective enough, would have been open-minded enough to have seen the circumstances, and you think you would have gone along with it?

Mr. LEE. It seems to me that the opportunities are so fabulous in medicine, it is not a compromise to go into generalist careers.

We do not have to become technically trained in a procedure based sub-specialty in order to make a tremendous contribution. One of the great things about medicine is that it is constantly advancing. We have to constantly keep up.

You can't stop when you finish medical school, when you finish residency. That learning process goes on continuously, and to me, the body of knowledge in medicine is a tremendous challenge and then to take that into a field of general medicine, family pediatrics, or family medicine.

Mr. BILIRAKIS. As a follow-up I would like to ask you an underlying fundamental foundational question which might sound unanswerable, but I would like to think that people like yourselves who worked on this plan certainly considered it.

We know that the pipeline for training many physicians is a good nine or ten years. I suggest to you it is a lot more than that if we consider the undergraduate school which is certainly a very major part of that pipeline.

So shouldn't we ask ourselves what happens to medical care in this country if—you and your colleagues and the administration are wrong about the needed mix of our physician supply and the characteristics of a quality physician? I mean, you are a physician, you are in it for the right reasons.

But certainly it has got to concern you. What if you are wrong? What if you have made the wrong guess? What if you have made the wrong decision and these people have gone this entire pipe line, then where are we?

Mr. LEE. One always has to look at what are the unintended consequences of any policy proposal. One of the great advantages of these hearings and the other hearings that Congress will hold is to look at those issues. What will be the unintended consequences of, let's say, the 55/45 figure.

The fact that that can develop over time, it gives not only the national council the opportunity to review, whether that is a correct

decision, but the Congress will have that opportunity obviously to review those decisions.

We are making the ultimate, final decision. Canada has just shifted their decision with respect to residents. They are going to increase the number of specialists trained in Canada.

We need to look at that over time. It is not an all or none decision, but it certainly is consensus that we need to move in that direction and those figures seem to be reasonable figures at this time. And the mechanism, the national council provides a mechanism for reviewing that both on an annual basis and then on a kind of a running basis over time.

Mr. WAXMAN. Thank you, Mr. Bilirakis.

Mr. Brown.

Mr. BROWN. If I could, Dr. Lee, I would like to follow up on one question of Mr. Bilirakis on some specialty—on specialization. Many specialists have argued that increasing the number of primary care physicians could inadvertently, one of the unforeseen consequences perhaps or difficult to predict consequences, could inadvertently cause the cost of certain care to go up due to symptoms being missed or diagnosis delayed as a result of the unfamiliarity of primary care physicians who might miss a situation under certain conditions.

What is the likelihood of that? What will that do to health care costs? What will that do to human suffering in those cases where they could be missed?

Mr. LEE. Well, that is of course a hypothesis. In Boston, a study was done that showed that, for the same outcome, the generalist provides the care for the same patient with the same type of problem at less cost than the subspecialties. So at least some evidence would not support that hypothesis of the specialist.

Clearly if somebody misses a diagnosis, it is costly for the individual patient. It is going to add to the costs. We also know that specialists perform more procedures than generalists for patients with the same problem. The Boston study did not have a comparison on outcomes.

The other side of that coin is if you have subspecialists providing primary care services instead of a generalist, they may be providing, as it appears to be the case, more unnecessary services for those patients. That puts the patient at some risk having procedures performed or getting more interventions than would be necessary. However, the question is, I think, a very appropriate question.

Mr. BROWN. Let me shift gears for a moment. Public health people in my district and public health experts around the country have said that the public health initiatives included in the President's plan, while laudable, may have a couple of serious problems.

One, that they are likely to be grossly underfunded. Second, that the current public health infrastructure is simply ill equipped, because it would be significantly overburdened without significant additional funds.

Talk to us about that if you would.

Mr. LEE. Well, there are two things. First, while we are not really discussing it today, there is significant funding proposed for those essential functions of the core public health. The surveillance

functions, determining what is the burden of disease in a particular county within a State, public health interventions, communicable disease control, chronic disease control, and community health education. There are significant authorizations requested in the administration's bill to support and strengthen those core public health functions.

The second is, with the plans on a capitated basis, they have an incentive to have population-based approaches as well as individual patient-based approaches. So they will have greater incentives to do things like immunize the people in their plans, to provide the screening, for example, like early detection of breast cancer for women over 50. The health department and the health plans will have common objectives with respect to the health status of the population, a big change in that partnership, a very big change in the role of health plans in achieving public health objectives.

So it isn't just the health departments. It is the health plans, and to develop those kind of partnerships will require a significant culture change. People in public health, based on our discussions, as well as people affiliated with organized delivery systems, are eager to move forward with these preventive services to improve the quality of care, and to realize potential cost savings for the plans.

Mr. BROWN. Paint the scenario, if you would, of how tracking, for particularly prenatal and immunizations, would work with that partnership; if you will, with public health and health plans like alliances.

Mr. LEE. With appropriate data and with provisions to protect privacy and confidentiality of individuals, you collect, the alliances would collect enrollment data, so you would know the socioeconomic status of the other individuals enrolled in the plans. You would have data from the plans on encounters so you would know whether a plan is providing immunizations. The health department would then be looking at the health statistics, as we do at the Centers for Disease Control and Prevention. Are there any measles cases in this county or State, any pertussis cases, any other cases of preventable infectious diseases that can be prevented by immunization?

So you measure the plan both on process—did they do the immunization as they said they would—and does that achieve the public health objective measured through these health statistics through the public health data systems. And, if a plan does not meet those kind of quality measures, people would not likely choose the plan; and, second, a State would say to the plan that they did not achieve these objectives. You need to take these measures in order to get your immunization rates up to 90 percent at the age of 2, age appropriate, or mammographies at a certain level or other preventive services, including prenatal care.

So with an adequate data system, we would have the information to judge its own performance, a hospital could judge its performance, physicians could judge their performance, and the plan's performance could be judged in terms of achieving these quality outcome objectives.

Mr. BROWN. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Brown.

Mr. Greenwood.

Mr. GREENWOOD. Thank you, Mr. Chairman.

Dr. Lee, I want to set the stage a little and ask you a question. There is a 500-bed, high occupancy academic medical center located in the inner city of Philadelphia which has a 73 percent Medicare and Medicaid caseload, with 93 percent of its free care patients classified at admission as "emergencies" or "trauma."

It offers free pre- and post-natal services to its community as well as undertakes extensive maternal and child health outreach services, yet its service area has an infant mortality rate exceeding some Third World countries. It is the largest provider in indigent health care in Pennsylvania, the busiest Level I trauma center in the city, with 60 percent of its trauma brought to its emergency room resulting from homicide.

In its service area, the tuberculosis and hepatitis rates have increased to rates which are two to three times that of other areas in Philadelphia and has uninsured cases involving AIDS, teenage pregnancy, drug abuse, and cancer which are typically more severe.

About 80 percent require nutritional intervention in addition to clinical treatment while 60 percent of the children are born to high risk mothers, with 15 percent of the newborns with an evidence of cocaine in their blood.

Due to the nature of its patient mix and the size of the institution, if it were no longer able to provide care for this community its caseload could not easily be absorbed by the surrounding institutions. A number of the academic health centers that serve as safety net providers are concerned about their viability. They are located in geographic areas where most of the uninsured reside and where too many providers, even if universal care is adopted, will be unwilling or unable to serve. As providers of last resort, these AHCs would be disadvantaged with respect to other providers and would be less attractive to health plans.

Now, the alliances, under the bill, the Clinton bill, are only required to insure that health plans have sufficient contracts with eligible centers to ensure that beneficiaries, quote, "receive appropriate treatment at such centers," close quote. All of these centers—we have six in Philadelphia alone—are concerned that the shorter stay, less expensive cases will be diverted to hospitals in a managed care network. They will leave it to the AHC's to treat special and rare diseases or provide the more extensive care and the expensive standby trauma centers, burn units, and neonatal centers.

In order to survive, maintain their research mission, and to serve the sicker and more complicated patients, AHC's must maintain a viable patient base, which includes the, quote, "bread and butter," less expensive shorter stay patients who could easily be enticed to the less expensive managed care hospitals.

The question is, how do you propose to ensure that these AHC's remain viable, particularly in the inner city setting I have just described?

Mr. LEE. Well, the first thing, of course, is by insuring everybody. The huge uninsured population problem would be at least resolved financially.

Second, with the academic health center fund would assure meeting those additional costs for patients referred to the academic

health center—for example, you mentioned the trauma center. Although we do not designate trauma centers in the plan as essential providers, it seems to me in situations like that they are essential providers and should be so designated. We did not include that in the plan, but that is something you could certainly consider.

In the health plans—now, there are two approaches that such an institution might take. At the University of Pennsylvania, they are developing, as I understand it—and I am actually going up there this afternoon—an accountable health plan. They are networking with physicians, bringing them into their network. So they will develop, in that case, an integrated delivery system that would be an accountable health plan itself.

And in San Francisco, what we have been thinking about at the university, when I was there they were thinking about, was that they would be a tertiary referral center and would not try to set up an independent accountable health plan, which means, then, having services that multiple plans would choose to use from that institution, and where the institutions involved, including a hospital in San Francisco, a public hospital, similar to the one that you described with this kind of caseload, with the quality of services provided—and you mentioned certain types of problems, AIDS, drugs, teenage pregnancy, cancer, trauma—that institution is undoubtedly a first class provider for those services.

One would assume that the plans would want to contract for those services and the patients would want to choose that institution as their provider. Patients in the fee-for-service plan will have a choice of where they go. In the preferred provider plans, they would also have a choice. If it is a closed panel group practice or staff model, there would be an additional option for people to choose a point-of-service plan. If an individual wants to go to such an institution, and the physician has not referred the patient, that option would be available under the proposals in each of the separate plans.

So I think with those kinds of provisions, we would be able to provide that this type of institution, if it is meeting the community needs as you describe could be an essential provider. It would not only be that, but it would also do the training and get the additional academic health center funds to help meet what are clearly additional costs for these kinds of patients that you describe.

There would also be, for the plan that included those individuals, a risk adjustment to the plan. And one of the things I think we need to look at in the Health Security Act is how can we assure that the providers who are taking care of those higher risk patients within a plan area receive the additional payments. In other words, it is not just the plan that gets risk adjusted, it is the provider that gets risk adjusted as well. We have not worked that out, but we need to work on that.

Mr. GREENWOOD. Thank you.

Mr. WAXMAN. Thank you, Mr. Green.

Mr. Kreidler.

Mr. KREIDLER. Thank you, Mr. Chairman.

I want to follow up on the question that was asked earlier regarding the VA medical residencies. Dr. Robbins, of UCLA, was to make a presentation here representing the National Association of

VA Chiefs of Staff but, unfortunately, because of the earthquake he is not here.

I would like, Mr. Chairman, if we could have that included in the record of this hearing.

[The prepared statement of Dr. Robbins follows:]

**Testimony of the National Association of VA Chiefs of Staff
(NAVACOS)**

**HEARING ON CLINTON HEALTH SECURITY ACT--PROVISIONS ON HEALTH
PROFESSIONS WORKFORCE**

Good morning, Congressman Waxman, distinguished Representatives, ladies and gentlemen:

My name is Alan Robbins; I am a physician, Professor of Medicine at UCLA, and the Chief of Staff at the Sepulveda VA Health System. I am here today to testify on behalf of NAVACOS, the National Association of VA Chiefs of Staff.

Mr. Congressman, I believe it would be useful to begin with a description of the VA's role in health professions education in this country. For 50 years, since Omar Bradley signed Policy Memorandum No. 2, the VA has had affiliation partnerships with our nation's schools of the health professions. Over 1000 institutions affiliate with VA hospitals where their students receive clinical training towards their degree or certificate. 100,000 students in over 40 health disciplines pass through the VA health care system annually, bringing inestimable benefits to these future professionals, to the VA health care system, and to America's veterans. NAVACOS is proud of VA's major contribution to health care education; it is one of VA's 4 statutory missions... "to educate for VA and the nation."

Foremost among these affiliations are the partnerships with our nation's medical schools. All medical schools with nearby VA hospitals or clinics have such affiliations. In sum, 104 medical schools are affiliated with 130 VA health centers. Affiliated VAs have unique characteristics: the medical staff are faculty members of the medical school, some maintain research laboratories at the VA, and all conduct patient care and teach medical students and residents at the VA facilities. Many faculty have part time appointments at both the VA and the university teaching hospital or county hospital. All VA residents are enrolled in fully integrated residencies sponsored by the affiliated medical school and its teaching hospital. Residents are matched to the ACGME accredited medical school program in their discipline, and VA participates in this program by funding the salaries and benefits for these residents while they are on rotation at the VA, as well as supporting the faculty and education infrastructure involved in their training. Across the country, VA supports 8600 residency positions annually, participating in all of the recognized specialties except for pediatrics and ob-gyn. Over 32,000 residents rotate through these positions each year for variable periods of time. On any given day, 8600 residents are on duty at

a VA facility. The VA system also provides clinical rotations for over 22,000 medical students each year. Most of these rotations are in general medicine, surgery or psychiatry. The VA proudly plays a major role in American medical education; 65% of the nation's physicians have received training in the VA system.

NAVACOS believes that the quality of patient care in the VA system is critically dependent on the presence of these students, residents and faculty. Their presence produces an atmosphere of academic inquiry and an attention to quality and rigor in patient care which benefits our veterans and insures that they receive care second to none. The condition of the VA before the affiliation policy was introduced in 1947 bears witness to the dependence of VA on this nurturing partnership. A federal system which offers non-competitive salaries and cares for some of the most complex and difficult patients available must offer its physician staff something of enduring value. VA offers its doctors the opportunity to be educators, to remain on the cutting edge of medical care, to have faculty appointments at the nation's preeminent medical schools and to provide the finest care to those who have served their country.

In looking to the future manpower needs of this country under health care reform, all parties concur that more generalists and fewer specialists must be trained. VA itself will need many more generalist physicians under health reform, because VA is converting from a hospital based system which provided episodic and tertiary care limited to veterans who met eligibility criteria, to an HMO structure with emphasis on wellness and continuity of care for any enrolled veteran and his family.

Since 1947 VA has participated in specialist training, especially in disciplines such as urology, orthopedics and ophthalmology, since these services were needed for the older veterans referred to VA hospitals for surgery or management of complex conditions. Despite the nature of its patient population, VA has always trained general internists as well, with up to 1/3 of resident positions supporting training in general internal medicine. Under health reform, VA will restructure its health care delivery to emphasize health care clinic networks, and interdisciplinary team care of groups of veterans who will receive all their care from the VA Health System. These settings will provide not only excellent primary care for veterans, but also a valuable opportunity to contribute to generalist training, both for VA and the nation.

VA has already begun this process of altering its investment in resident programs. Just in the last three years, the generalist share of VA's portfolio has risen to 38% and further increases are planned as rapidly as VA can develop the primary care sites for its patients. For over five years, a pilot program has been in operation at the Sepulveda VA, called PACE (Program for Ambulatory Care Education, which has been deriving what curriculum and

resources are needed to provide excellent primary care education for medical students and residents. Recently PRIME, an RPP to award resident and associated health trainee funded positions to facilities which provided continuity of care in a team setting, had over 70 applicant VAs. In July 1994, over 250 medical residents, 150 nurse practitioner and physician assistant trainees, and 300 other associated health trainees will begin training at 50 VA sites around the country. In the Los Angeles area, VA facilities will receive over \$ 1 million in new education funds and 65 positions.

These are just a few of the initiatives through which VA is already restructuring its training programs for residents, and for all health professions trainees, so that the federal funds which VA expends in fulfilling its education mission will contribute to the new workforce imperatives.

Given VA's ability to control its allocation of resident positions and resources, and its commitment to continue its support of medical education, both in salaries and indirect costs, the various proposals to achieve national control of GME funding and positions are of some concern to NAVACOS. Specifically, we are concerned that unless VA continues its own funded resident positions, there will be no residents in the VA system in the future. If VA lost its opportunity to participate in resident training, it is very likely that this would bring down the whole affiliation partnership. It is because of the academic milieu and the opportunity to teach that faculty physicians are attracted to VA. NAVACOS does not want to see the VA health care system return to the back ward, warehouse status which prevailed before the affiliations. Our nation's veterans deserve first class care.

We are concerned about the potential loss of VA's role in resident training because of two threats: the locus of control of positions/funds and the downsizing of the total number of residents to be trained. NAVACOS understands that the total number of residents in training must be reduced, and that logically, these reductions will take place in the specialist training programs. What we fear is that if each medical center were left to its own devices, or, if reduced quotas for every training program were handed down from some central body, VA resident positions would be preferentially cut because specialty residents (eg. neurosurgery) would be a highly valuable commodity in settings which generate income for the academic medical center. NAVACOS supports a process for deciding where the cuts would come which is based on a quality assessment of specialty resident training programs, preferably with the help of ACGME. In such a scenario, cuts would be made vertically, by eliminating entire training programs of poorer quality, and those that were left would retain a critical mass of residents, including the VA share in each residency, to provide an excellent training experiences for future specialty physicians.

NAVACOS also believes that VA will provide excellent training opportunities in primary care for general internal medicine residents in its reconfigured health care system. Residents will work in interdisciplinary teams, work with a variety of other health care providers, learn to provide health maintenance and continuity care, and work in remote rural sites as well as urban settings. NAVACOS anticipates that many more VA resident positions will be offered in generalist training within a few years. We believe that VA will lead the academic medical centers in providing opportunities for high quality generalist training, and that the reshaping of VA's portfolio will be a significant contributor to academic medical center efforts to reach these training goals. Please recall that VA does not train in pediatrics or ob-gyn, and at present has very few family practice residents because of the absence of women and children. As VA moves to provide care for the dependents of enrolled veterans, these training opportunities may also open up. Again, NAVACOS does not believe that VA will have the opportunity to participate in the new, downsized world of resident training if decisions about allocation of positions are made in other loci--whether that be a national agency other than VA, a myriad of state agencies, or academic medical center based consortia in which VA only has one vote. Unless we allocate our funded positions towards the total positions approved for a medical center, we do not believe that those positions will be assigned to the VA health system.

In summary, NAVACOS urges that the downsizing of the national pool of resident physicians be accomplished based on objective measures of program quality, and that decreases be achieved by eliminating weaker programs, not by horizontal cuts across all programs. This downsizing should be accomplished by a single national review of all specialty programs, against targets established by the Advisory Board. Once the US GME system is rightsized, NAVACOS believes that VA will contribute meaningfully to meeting national manpower goals for generalists, as well as psychiatrists and general surgeons, (two other disciplines in scarce supply where VA has major training capability). Whether the quotas are set by state or by consortium, we are sure that VA will use its funding and its training opportunities to meet these goals. NAVACOS is sure that VA's contribution to the federal funding invested in training future physicians will be invested in training the workforce needed by "VA and the nation" under health care reform.

Mr. KREIDLER. Dr. Lee, as you know, the VA supports some 8,600 residencies in 130 VA facilities through affiliation with some 104 medical schools. They tell us that nearly two-thirds of the Nation's physicians receive some training by rotating through these assignments, and of course these programs help the VA maintain a high quality of care and a highly qualified staff.

They understand the need to reduce the number of residencies overall, particularly in subspecialties, but they are afraid medical schools may cut them out of the loop as they lose residency slots. They think medical schools will prefer to keep their residencies at their own teaching hospitals where they produce revenue.

First, do you think this is a valid concern; and, second, would you be willing to discuss the issue with the VA and work with them on a solution? Could your office give us a written response to the concerns expressed by Dr. Robbins' statement?

Mr. LEE. Certainly, we will work with the VA. We would work with the chiefs. We would give you a written statement in response.

I think you need to address that question to the deans of the medical schools. Similar concerns have been expressed to us by public hospitals who are affiliated with the medical schools.

One of the final decisions is whether the funds should go to the plan. In the act, as it is now proposed, funds would go to the training programs. Because the VA is intimately involved with the medical schools with most of their residencies, it is hard for me to imagine they would, in fact, be cut out because they are absolutely essential. In other words, you cannot have a well-rounded residency program in many institutions without having the VA hospital participate.

But I think we absolutely would not want them to be cut out because they do such a good job and they have been so important. We will work with the VA and with the chiefs of staff and of the chiefs of those training programs to assure their participation.

For this committee, neither the Public Health Service has jurisdiction over the VA, and this committee does not, but we will work closely with them, and we will appreciate your concerns very much.

[The following information was received:]

We share the VA's concerns that their quality training programs not be damaged as a result of the reduction in the total number of residency positions allocated to meet the Nation's needs for physicians.

Because the VA funds their training positions through appropriations and the perceived high quality of training received in these facilities, there is an incentive for teaching hospitals to rotate residents through VA programs. We believe that if this situation remains unchanged, VA training programs will continue to successfully compete for residents.

Public Health Service staff have been meeting with VA staff to share data and information so that we avoid undue hardship to the VA health delivery system, while attaining our national workforce goals. We are anxious to continue this dialogue and to meet with the National Association of VA Chiefs of Staff (NACACOS) so that we may consider their concerns in our policy development.

Mr. KREIDLER. Very good. I am sure Dr. Rowland would like to see that response, too.

I especially want to commend you for including the capacity building program for essential providers in the community, because the community health centers in my State are trying to set up a network and could use this kind of assistance.

Do you contemplate that community health centers, public hospitals, and other, quote, "safety net," unquote, providers might form their own health plans to compete with the alliances?

Mr. LEE. Yes, I am very interested in seeing physicians, local health centers and hospitals work cooperatively together to develop integrated delivery systems where they then have the power to negotiate with the plans. That is part of the reason for the access capacity piece of this proposal. It does put the resources at that level in the hands of those who have had the experience. I am delighted that the community health centers are moving forward in that direction in your district. This, I think, would foster and support that kind of leadership.

Mr. KREIDLER. Of course in my State, which is the State of Washington, it is somewhat self-evident because they enacted a managed care reform program comparable to the President's already last year, so they are kind of ahead of the curve and that is why the community hospitals and community health centers are stepping up to this issue rather aggressively.

Mr. LEE. Good. We should talk some more about that because I think we have a lot to learn from what Washington has done already.

Mr. KREIDLER. Thank you. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you very much, Mr. Kreidler.

Mr. Paxon.

Mr. PAXON. Thank you very much, Mr. Chairman.

There is very little doubt that if this were normal circumstances that we were considering the President's and other proposals to reform our health system we might be spending a full year on this subcommittee just dealing with the medical education question and the allocation of slots and this whole issue. There has been far too little discussion of this issue, in my view.

Maybe I am somewhat biased on the subject. I come from New York where we have 15 percent of all GME's, 14,800 in 1993. I have in my community, the communities I represent in the Buffalo, Rochester and Syracuse areas, three medical schools. So we have had some discussion of this issue, and there is a great deal of concern in the community at several levels about the President's plan and its impact upon medical education in our region.

We have been very fortunate not only to have good medical schools, but many physicians who come to our community for medical education, medical students end up staying in our communities in upstate and western New York.

So, Doctor, I am concerned about this for several reasons: Number one, what will this do to the quality of our medical schools; what will it do economically to a State like New York, with 15 percent of all graduates, and the list goes on and on? I won't get into some of that today but a couple of quick thoughts, because we are apt to spend more time on this as we go along.

We have, first of all, Doctor, approximately 70 percent of our graduates from New York, or more particularly in some of the schools, are in specialties, and we will shift that suddenly to 45 percent, and I am interested in how exactly do you intend to accomplish that other than by fiat, taking into consideration something along the lines you might have a certain medical school with

a renowned renal specialty department or specialist in education and suddenly that school is going to find that it has to, its slots are allocated to what are in orthopedics.

How do you suddenly take someone's specialty in renal medicine and shift them to orthopedics, other than saying to the school you accomplish that; you take care of it?

Mr. LEE. First on the allocation. One, we would be glad to provide you with a more detailed analysis of New York State, particularly with an overall picture. We are looking at that in more detail.

Mr. PAXON. Thank you.

Mr. LEE. First, the allocation of the slots by the national council. First on quality. One would assume those are quality programs and they would not be shifted arbitrarily from renal to orthopedics. That just would not happen.

Second, it is an historical pattern. New York has always been a leader in graduate medical education, so that those factors would be primary factors in the decisions of the council with respect to where the residency training programs would be funded.

Mr. PAXON. So, then, Doctor, if that be the case, what you are going to do is say, all right, those schools have that background; you are going to allocate to other schools and other participants of the country in other primary spots?

Mr. LEE. No, if you look at the aggregate number of residents, we are now at 135 percent. Let's say you move gradually to 110 percent, as a hypothesis. The number of residents currently in general medicine, family practice, general pediatrics, obstetrics and gynecology would have to be increased slightly to achieve that 55 percent goal. If you then have to reduce the number of medical subspecialists and some other subspecialists that are in over supply, again that is a gradual process.

There would be transition funding for those institutions that decided to reduce the number. Some institutions may do that in advance of these policies going into effect. So that the process will be an interactive process in making the decisions. It would be a gradual process, or at least I think—it depends on the decisions Congress makes how gradual that process is, and it would be based on quality of the residency programs. So I would not anticipate that there would be a big shift away from some of the residency programs in New York, although there will be some reductions in numbers of these subspecialties that are in over supply.

Mr. PAXON. There is no question. Doctor, I would very much appreciate and take you up on your offer to have a more detailed analysis provided of your review of New York State.

Mr. LEE. We hope to finish that in about two weeks.

Mr. PAXON. I will be very much interested, and if I could conclude with the thought that, obviously, I come to this with a different viewpoint. Every day in our office, as in similar congressional offices, we spend a lot of time trying to have Federal agencies assist our constituents. In many cases these are relatively routine and non, or issues that do not affect the life and safety and security of people in their individual lives.

Doctor, I certainly come at this with a view it will be very difficult to find, in my view, a government bureaucracy that will be able, on an annual basis, to shift medical education slots based on

these varying criteria that are being prepared and discussed. We will get into that, certainly, and I will be interested as it goes along to determine whether or not the same type of analysis could be applied to our legal specialties. Maybe take a look at corporate and trial work and look at maybe shifting some of them to, say, public defenders, just off the top of my head.

Mr. LEE. I will make one point on that. In our graduate medical education, the current policies, the standards by the Congress for Medicare payment have been a significant factor in producing the amount of distribution that we have. We reward subspecialty procedure-based services in the Medicare program. We have permitted, for example—again I will use the UCSF example—but in the department of medicine, half the income from the department of medicine came from cardiology. Now, why do we have cardiology residents? Obviously, it helps us generate or helped that department generate the revenue it needed. Those were related to Federal policies. We have provided incentives to produce the kind of specialty maldistribution we have today.

We are proposing to reexamine those policies, to look at the direction health care is going, which is towards organized delivery systems, towards more managed care. Rochester is, in fact, an example of that many years ahead of the rest of the country. We must produce the kind of physician balance that is needed to deliver the services that we need in the country. It is a very important issue. It is very much affected by Federal policy and we are proposing that we need to shift those policies because of the adverse consequences as we now see them of the policies that have evolved.

Mr. PAXON. Thank you very much, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Paxon. Your time has expired.

Mr. Slattery.

Mr. SLATTERY. Thank you, Mr. Chairman.

First of all, I want to commend you, Mr. Chairman, for holding this hearing today, and I think it is obviously very timely and, Dr. Lee, it is good to see you. As you know, Dr. Lee, there are a lot of us who represent rural parts of this country that are very concerned about what effect the various proposals will have on our regions of the Nation.

I would like, first of all, to give you an opportunity to assure us that the proposed Medicare cuts are not going to have an adverse effect on funding of rural health care providers. If you would like to use this opportunity to put to rest some of the deep concerns that we have about how these proposed cuts will actually be implemented, I would like to give you that opportunity.

Mr. LEE. The Medicare reductions are really reductions in the rate of increase in expenditures, and principally, although there are some specialists that will in fact receive reductions, those are procedure-based specialists.

And if we look at the physicians, particularly in the Medicare payments, in those fee schedules the proposal is to increase payments for evaluation of management services and to increase the bonus payment for physicians in rural areas. So that two parts of Medicare, as we slow the rate of increase, will be shifting more towards the generalist physician.

Now that is not——

Mr. SLATTERY. So the bottom line, Dr. Lee, of what you are saying is that physician reimbursement in rural areas will actually be increased?

Mr. LEE. Should increase.

Mr. SLATTERY. Under this proposal.

Mr. LEE. Should increase.

Now, for rural hospitals, they have increased payments in recent years. Their payments will now be under the same policy growth limits as are applied to hospitals throughout the rest of the country.

Mr. SLATTERY. Which, from our perspective, you understand, we see as sort of locking in a disproportionate, unfair system.

Mr. LEE. I think, again, that is an issue that you clearly will be looking at.

The other part, and the part that is in the public health initiative that I think is important in terms of rural areas, is the access initiatives which would provide additional funds, particularly capacity expansion, to assist physicians in hospitals in rural areas to develop the networks in rural areas.

We have talked to physicians from rural areas who would be very interested in doing that. It would not be just in that case of a modern health center, it would be physicians who have been in practice who would then network with hospitals and other providers in the rural area.

Mr. SLATTERY. If properly implemented, certainly the changes in the National Health Service Corps.

Mr. LEE. That is another.

Mr. SLATTERY. The community health centers and the tax incentives and loan forgiveness ideas to encourage primary care physicians to practice in rural areas. All of that makes sense and will hopefully alleviate some of the shortage problems we are experiencing, but I am very concerned about how these Medicare changes will affect rural providers.

Another concern that I have is just the whole question of the relationship between the Federal Government's regulatory responsibilities in this program and what we envision the States being able to do as we structure these networks and as we press ahead with the other changes.

Under title III, subtitle (e) in the section on medically underserved populations, the \$2.7 billion set aside for 1995 to the year 2000 in grants and contracts are made through the Secretary's office and are limited to a consortia of public or private health care providers and to qualified community practice networks. But there is no role in this legislation and no funding for the States indicated. In other words, this whole question of how this will be put together appears to be left to the Federal Government.

Some of us are very concerned about the need for us to make sure that the States have maximum flexibility in terms of shaping these networks and to make sure that we do not have to be plugging into HCFA or its replacement agency at the Federal level to get approval for what the network will look like in Colby, Kans. It is very important for us to make sure we have maximum flexibilities given to the States.

Now, the other concern I have is that the plan contains protection for essential community providers, including the community health centers that we have talked about and other Public Health Service programs. Again, there is no explicit role for the States to play in determining who those providers are going to be, and I think it is very important for us, and I wanted to get your comment on what role you envision the States playing in defining these networks and also in defining who the essential community hospitals or providers are going to be.

Mr. LEE. First of all, on the networks. The alliance, first of all, will be designated by the State, and the State does play a major role in that. They will also play, I think, a significant role in determining the criteria that will be used to qualify plans in a particular State. In other words, many insurance plans now do not have to achieve certain quality objectives. Those could be a requirement of a State on a health plan. They may have to achieve, certain quality outcome objectives and have data that would permit the State to evaluate their performance. We would see the State as playing a significant role in evaluating plan performance with respect to public health objectives and developing partnerships with the private sector and with the plans within the States.

I think you raise an important point about the role of the States with respect to title III and with respect to the access initiatives. With the core public health functions, clearly those funds go to the State. The States determine how those funds will be allocated and the priorities within the State, although they have to meet certain objectives.

I think we need to have some more conversation on the access initiatives and have more discussion about what specifically should the role of the States be, and, Mr. Chairman, we would be glad to work with this committee on that set of issues.

Mr. WAXMAN. Thank you very much.

Mr. SLATTERY. If I could, I would just observe I think it is very important for us to make sure that the States have maximum flexibility in terms of designing these networks and designing the access structures that we are talking about.

Mr. LEE. Well, as you know, the President as a former Governor has been very strong on that, and that is the reason the plan emerged as it did, not as a single-payer plan but as a plan that would give the States much more flexibility. This is an area that we need to look at a little more.

Mr. SLATTERY. Okay. Thank you, Mr. Chairman.

Mr. WAXMAN. Sounds like you have an interest in the States having a lot of flexibility.

Mr. SLATTERY. Yes, you might say I do. The Chairman is very perceptive, isn't he?

Mr. WAXMAN. Thank you, Mr. Slattery.

Mr. Washington.

Mr. WASHINGTON. Thank you, Mr. Chairman.

Dr. Lee, my concerns are similar to those expressed by my friend from Kansas, Mr. Slattery. I don't represent a rural area, and I try, as often as I can, not to be provincial about issues that affect the entire country—not to suggest that he was—but it seems to me there is a striking similarity between the lack of health care re-

sources in the rural area and in most metropolitan areas, and I represent a highly compact district of Houston, Tex., that has among the highest incidence of low birth weight babies in our State and third in our Nation; that has an extraordinarily high incidence of AIDS per 100,000 in population; we can go down the list and the litany of all the health care problems that drive us, some of us, to the need for reform, and in every category the part of Houston that I represent would be on the list.

I have to say that it seems to me that there are several concerns: One, of course, we have many health care resources, the failed Texas medical centers, within the shadow of these very people who are doing without health care at all. And I am interested in following up, if I could briefly, on the long-range impact of redirecting our medical schools toward the production of more primary care physicians and fewer specialists.

How are we going to, first, get the physicians to give up the expectations of great financial rewards, as some of them have, that send them to the specialty medical schools and into the specialty areas to begin with; and how are we going to redirect them both to the rural areas and to urban centers where they are needed?

Mr. LEE. First, we do have these proposals with respect to graduate medical education by gradually shifting, the incentives for the physicians in practice; to affect the kinds of environments in which they can practice, and, not only the financial rewards but the professional rewards as well.

Part of the plan is to develop integrated systems where physicians working together with nurse practitioners, and, in some cases, physician assistants and others. We will add incentives to provide more preventive services and more primary care services.

Inherent in the proposal, with the development of the managed care plans, would be an incentive towards prevention; more prenatal care, and immunization. I was in Houston recently and the head of pediatrics informed me that only 14 percent of the children up to the age of 2 were appropriately immunized in some areas of Houston. A significant part of that problem was not that the families were not taking the kids in to see the doctor. But rather that the doctors were not immunizing the kids. So we have a big job to do of changing the incentives within the system. It is not just patients, but also doctors who need to be educated about the need for immunization. There needs to be some of that, but there needs to be incentive changes.

Problems in the inner city areas are extraordinarily difficult to solve in terms of providing practitioners opportunities. Physicians in solo practice find it impossible now to practice in those locations. You have to have integrated systems. You have to have a center. You have to have a place to treat drug addicts. There are other problems in those inner city environments that make it very difficult for an individual, let's say, to establish a practice. In a rural area, the isolation and some of the other problems need to be dealt with. We are trying to do that and are cognizant of those.

The reason for the need to develop the integrated delivery systems, community based, with the providers in the area to reach out into, and I am sure Houston has areas where there are large numbers of people with access to no physician, to develop a network

that would reach out, provide either outreach workers into those areas, so-called enabling services, or in fact have a center, like a community health center, that would be in the neighborhood, that would be staffed with 24-hour backup with a regional hospital or medical center. Not possible now because they do not pay for it. There is no way to pay for that care now.

So you have to cover everybody. You have to provide adequate payments. You have to change the incentives, and you still have to develop these access initiatives with the integrated systems.

Mr. WASHINGTON. All right, sir. What are we going to do about—I am concerned as much about the people who may live in my district as the people who may not, because they show up at our public hospitals. They are undocumented persons from other countries, principally from other Spanish speaking countries. Some of them wait in their automobiles for a week or 10 days on the parking lot at the hospitals until they go into active labor because they know, regardless of the policy of the hospital, no doctor is going to turn down a woman in active labor when she presents herself at a public hospital.

They do not get immunized, and under the President's plan they would not be immunized because they would not be eligible for health care resources, which I find to be ludicrous, but I am not a physician.

So you are putting children out here who have no possibility of being immunized with children that we all admit should be immunized and are not being immunized. And it seems to me measles does not know an undocumented child from any other, and if we do not, if for no other reason immunize all the children who are going to fit under the President's plan, then we are right back where we started. And how can you divide health care resources on where a person happens to be?

Mr. LEE. Well, the decision on the undocumented aliens to not include them in the plans was a very carefully thought through decision.

Mr. WASHINGTON. I hope it was also very difficult.

Mr. LEE. It was extremely difficult.

Now, Medicaid funding would continue for those acute services that are provided, like the emergency room or maternity care. The safety net providers would continue to provide for everybody, for undocumented as well as citizens.

Mr. WASHINGTON. But not immunization.

Mr. LEE. Oh, yes, the immunization of the public health program, the public health core functions, could include funds for immunization of undocumented.

Mr. WASHINGTON. Would or could?

Mr. LEE. Would. Would include.

And, finally, there would be additional funds for those hospitals that have a disproportionate percentage of low income and, of course, these individuals would fall into that category. So there would be some additional funds available for those institutions.

It is not a comprehensive approach, but it is an effort to provide an adequate level of care, essential care for those individuals. And it is not clear what would happen to those undocumented aliens who in fact are working, who have cards or whatever and are em-

ployed, and their employers are required to provide insurance for their employees.

Mr. WASHINGTON. So they would be covered.

Mr. LEE. One would assume. But I cannot—

Mr. WASHINGTON. I understand it is not your area. Someone else is providing the funding. Thank you. Thank you for your answers.

Mr. LEE. Thank you.

Mr. WASHINGTON. Thank you, Mr. Chairman.

Mr. TOWNS [presiding]. Thank you. The gentleman's time has expired.

Dr. Lee, residents provide a lot of care in New York hospitals. If residency slots are eliminated, some of them will have to be hired as a salaried doctor to replace that person.

Yesterday, the New York Times had an article, which you probably saw, which predicted replacement would double the cost of these positions. Where would the hospitals get the money to pay for salaried doctors?

Mr. LEE. Well, let me just talk at a couple of levels. First, I think everybody agrees we ought to mainstream everybody; not have some people in the community dependent on residents for their care. I think those hospitals would agree with that as an objective.

Covering everybody provides those hospitals with assured funding. It eliminates bad debts and charity care, and many of those hospitals are providing a lot of that: uninsured patients, various patients where they are not getting any payment for the care. So there would be increased funds to those hospitals to pay them for the care that is provided.

I indicated earlier that we will be providing to the committee a more detailed analysis of graduate medical education in New York so that you will have more factual information to make your ultimate decisions—but if you downsize these gradually, any individual institution in any given year would have a reduction of perhaps three or four residents, possibly.

New York hospitals are already recruiting nurse practitioners and others, physician assistants, to provide those services. That is a process that is already ongoing.

One of the reasons we want to expand the nurse practitioner programs and the PA programs is to provide practitioners who can provide many of those same services. That would increase the cost somewhat, but with these additional resources, we think it would be effective. With a combination of the Federal funding, which would be 100 percent of the resident's salary in the first year, 75, 50, 25, it would be enough to work through that downsizing.

And we do not anticipate, because of the quality of the training programs in New York, that there would be a disproportionate reduction of residency training positions in New York in these medical subspecialties and in many of the hospitals. And the Health and Hospital Corporation has as a goal the movement of a lot of care out of the hospitals into ambulatory care sites, which will require more generalists and fewer of the kinds of inpatient subspecialists that are now there in residency positions.

So that some of the objectives are going to be moved towards more ambulatory care. And the second is this more gradual movement. The third would be the more adequate funding of those insti-

tutions to provide for those additional costs. I think those would do the trick.

Mr. TOWNS. I just find this interesting because in more than one study New York hospitals have predicted that they would lose more than \$4 billion, that is "B" as in baseball, under this plan. And how much in terms of transition funds are you talking about that you are going to provide?

Mr. LEE. First of all, we need to give you a separate analysis, which we are in the process of doing, for New York, including the hospitals, because I don't have that data in my head. I have more information. I am talking about the residency training programs. We will provide the committee with a full analysis of the impact on the hospitals in New York, including the teaching hospitals, so you will have a separate conclusion from that analysis. I can't speak for New York until we have done a careful analysis ourselves and can give you the figures and the conclusions.

Mr. TOWNS. We are very concerned because New York happens to be an area that is high in undocumented population. That was just talked about briefly: AIDS epidemic, tuberculosis crisis, epidemic. And then to look at some of the things that have been proposed here, we feel that we are going to get really the short end of the stick, and I would like to get that analysis and I would like to get it as soon as possible, because it seems to be a lot of information is coming out on the other end that does not quite agree with what you are saying.

Mr. LEE. I think New York will not get the short end of the stick either in the aggregate or in the specifics. And both in terms of the total funding for care, in terms of the resources that will flow into New York, and particularly in areas, the district such as you represent, where there are a lot of underserved individuals, our goal is to assist those communities in developing the kind of networks that are needed that meet the needs of the patients for ambulatory care and for comprehensive care.

The last thing that we want to do is in any way not meet the needs of those through this reform. We want to meet the needs with respect to graduate medical education in the academic medical centers. If the current trends continue, without some major change in policy, such as we have proposed or has been proposed in the Health Security Act, the academic health centers are going to be in much more serious trouble, and many of them in New York are in serious trouble now because of the large numbers of uninsured individuals in places like Presbyterian Hospital. This is an extremely difficult financial situation. We want to provide you with this information, and then if it does not look right to you, obviously, we are open to modifications that would produce the right kinds of policies to meet those needs. The purpose of this whole exercise is to meet the needs of the American people wherever they are, and we want to work with you to achieve that objective.

Mr. TOWNS. I like that statement, that you are open.

Mr. LEE. Absolutely.

Mr. TOWNS. I like that. I am going to end on that note. Thank you very, very much.

Mr. GREENWOOD. Mr. Chairman, with your indulgence, can I ask if the analysis referred to for New York is an analysis being done for all of the States?

Mr. LEE. We are doing an analysis for each State and we can also do a more detailed analysis for Pennsylvania, particularly for Philadelphia.

Mr. GREENWOOD. I would like to request, if I may, that you provide me with the Pennsylvania data.

Mr. LEE. Glad to do that.

Mr. WAXMAN. Dr. Lee, thank you very much for your presentation to us, and particularly for your willingness to work with us to make this bill a better bill.

Mr. LEE. Mr. Chairman, thanks very much for the opportunity. Look forward to it.

Mr. WAXMAN. Thank you.

Our first panel today includes a number of witnesses representing a variety of essential providers of health services. Jesse Trice is the Chief Executive Officer of Economic Opportunity Family Health Center in Miami, Fla. She is testifying today on behalf of the National Association of Community Health Centers. Larry S. Gage is President of the National Association of Public Hospitals. Joe Gallegos is Executive Director of the Health Centers of Northern New Mexico, and President of the New Mexico Primary Care Association, a coalition of 48 primary care clinics. Thomas Rozek is President of Children's Hospital of Michigan in Detroit, and is a trustee of the National Association of Children's Hospitals and Related Institutions on whose behalf he is testifying. And Dr. Donald Trunkey, who is Chairman of the Department of Surgery of the University Hospital in Portland, Oreg., and a member of the Board of Trustees of the Coalition for American Trauma Care.

We are pleased to welcome you to our hearing today. Each of your written statements will be included in the record in its entirety without objection, so I would like to ask each of you to limit your oral presentation to no more than five minutes.

Ms. Trice, we will start with you. There is a little button on the base of that mike. If you will push it forward and pull it close.

STATEMENTS OF JESSE TRICE, CHIEF EXECUTIVE OFFICER, ECONOMIC OPPORTUNITY FAMILY HEALTH CENTER, ON BEHALF OF THE NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS; LARRY S. GAGE, PRESIDENT, NATIONAL ASSOCIATION OF PUBLIC HOSPITALS; JOE GALLEGOS, PRESIDENT, NEW MEXICO PRIMARY CARE ASSOCIATION; DONALD D. TRUNKEY, MEMBER, BOARD OF TRUSTEES, COALITION FOR AMERICAN TRAUMA CARE; AND THOMAS M. ROZEK, TRUSTEE, NATIONAL ASSOCIATION OF CHILDREN'S HOSPITALS AND RELATED INSTITUTIONS

Ms. TRICE. Thank you, Mr. Chairman, I guess it is working.

On behalf of the National Association of Community Health Centers, which represent really over 700 community and migrant, as well as homeless health centers that provide comprehensive health care to over 7 million underserved Americans in 14 sites, I am pleased to say that we at the national association support the President's plan.

Mr. Chairman, today, because you have our written testimony, I would like to direct most of my remarks really to the local level because I am on the firing line of where the underserved are that is either going to benefit or not benefit from many of the reform plans that are being discussed. So I want to, if you will, share with you what is going on in Miami, Fla., because I do run a large comprehensive primary health care center in Miami, Fla., that is located within the inner city, and we serve more than 50,000 people a year. And as we heard when Dr. Lee was testifying, our people have, a large percentage of them, have HIV and AIDS disease. We have a large substance abuse population, with many of our women delivering substance abuse children.

We do have problems of maintaining providers within the inner city. But as it has to do with the President's plan, that I support, I would like to point out some specific areas of concern. One of those areas has to do with a new plan that is proposed, and my understanding of that new discretionary plan is that a new organization will put together, if you will, I guess the networks that we have been talking about that will include some enabling services.

From my perspective, I would like to have this committee really look at the community health center movement and what it has done and what it can do, and I raise the question of why a new discretionary program is really needed. I believe that family planning, community health centers, and all the others we have talked about have provided the quality of care and can reach the population that we are talking about.

Another comment that I would like to make has to do with the intense growth of HMO's in the city of Miami. Just in the past three years we have gone from 3 Medicaid HMO's to more than 14 last month, and I know that managed care is something that this committee is very interested in and has looked at from a number of perspectives, and I am not here to say whether it is bad or good, but what I would want to point out, Mr. Chairman, is managed care often does not increase resources.

I am here really to speak for the inner city residents, and in talking about additional resources, I guess what I would hope this committee would remember that there are wide disparities in the morbidity and mortality rates for, particularly African Americans and other Americans, and if we in fact want to reduce health care costs, and that is what I understand reform is to be all about, we cannot forget that improving the health of the inner city residents has to be moved to the top of the ladder.

Thus, when I talk about increased resources, I am really talking about the need to have more access and availability, and the only way we can do that, and I know my time is up, is to be sure that there are more resources within the inner city at a time when our people can take advantage of those.

I hope that there will be time for me to speak just a bit more on some of the other issues, Mr. Chairman.

Mr. WAXMAN. Thank you very much. Your full statements can be in the record, and we will have a chance for questions and answers and we will get to some of those other points you wanted to touch on.

[The prepared statement of Ms. Trice follows:]

**STATEMENT OF
THE NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS
HEARINGS ON HEALTH CARE REFORM
AND THE MEDICALLY UNDERSERVED**

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE, the National Association of Community Health Centers (NACHC) is the national membership organization of over 700 community, migrant and homeless health centers providing comprehensive primary care services to over 7 million underserved Americans in 1400 sites across the country.

NACHC and its member health centers are well aware of the failures of our health care system, in particular because we care for millions of Americans who have been forgotten or left behind – unserved, or poorly served at best – by the existing health care system. In this context, health centers strongly support the President's call for meaningful health care reform to provide universal coverage to all Americans that can't be taken away, improve access to care – especially to preventive and primary care, and contain health care costs.

The needs of the underserved in health care reform are clear, and attainable this session of Congress:

- The underserved need a place to go for entry into the health system – a medical "home" that responds to their unique needs, that is geographically and physically accessible, culturally and linguistically competent, and available during evening and weekend periods; and that offers comprehensive primary care and "enabling" services, like transportation, translation and outreach. Universal coverage, though essential, is not enough, as access to health insurance does not necessarily mean access to health services;
- The underserved need an adequate supply of physicians and health professionals who are trained to understand and respond to their unique needs and health care problems; and --
- They need the assurance of knowing that the essential community providers which have historically served them will be able to continue doing so, through initiatives that provide adequate reimbursement (taking into account the inherently higher costs of caring for them) and risk contracting safeguards designed to protect their fiscal solvency.

We want to work with the President and Congress to capitalize on this golden opportunity – let's make health care reform work for all Americans. Clearly, we now

have the best opportunity in over half a century to extend access to affordable, quality health care to every American. The President's leadership will be essential in seeing the legislation through to final enactment. As presented, the President's plan makes several vital contributions toward improving access to health care and ensuring health security by:

- extending comprehensive coverage to millions of people who are currently uninsured or inadequately insured, with benefits equal to or better than those offered by many of the largest companies;
- eliminating current industry practices of denying or discontinuing private insurance coverage because of previous or current health conditions, or due to a change or loss of job;
- proposing to substantially reorient our health care system -- including the training of physicians and other providers -- to focus more on low-cost, high-payoff preventive and primary care, including coverage of important preventive services;
- proposing to expand and improve preventive and primary health services in underserved rural and inner-city areas;
- recognizing and safeguarding the key role of health centers and other "essential community providers" in caring for low income and underserved communities.

With the inclusion of these elements, President Clinton's proposal lays a solid foundation for achieving effective national health reform, and for ensuring that every American -- no matter what their circumstances -- has access to affordable, quality health care.

As much as NACHC and its member health centers support the President in his efforts to place health reform and universal coverage at the top of the nation's agenda, we must note that several elements found in the Health Security Act raise serious concerns about how well or poorly the reformed health system will serve the unique needs of America's underserved. In particular, the Health Security Act relies heavily on a system of managed competition, under which several health plans -- most of the managed care type -- will compete for Health Alliance enrollees, ostensibly on the basis of price and quality of care. This focus on managed competition could work to assure care and at the same time contain costs for most Americans. Yet while managed care has been cited frequently for its successes in effectively organizing available local health resources to improve access to health care while at the same time holding down the cost of care, there is no evidence that the presence of managed care in a community has successfully increased the level of available resources there, a critical factor in improving the health of underserved communities.

Moreover, managed care entities and HMOs have historically avoided the underserved

because of their unique needs and inherently higher costs. A market-based, competitive health system with a foundation in managed care, as envisioned in the Health Security Act, means that in the end costs will overwhelm all other considerations. The most expensive patients in the health system -- the underserved and those in greatest need of health care -- will likely encounter significant discrimination and barriers to obtaining health care services. For some areas and populations -- in particular low income, rural and inner-city minorities, and other at-risk Americans -- this approach may not improve access to care, and could even prove detrimental.

This fear is further heightened by the limited nature of proposed federal cost-sharing assistance for low income persons and families. Under the President's bill, federal subsidies would cover some or all of the employee share (20 percent) of the weighted-average premium for employed individuals with incomes below 150 percent of the federal poverty level; however, the subsidy will not cover premium charges by plans that exceed the weighted-average premium. This limitation could effectively restrict the choice of poor persons to only low cost plans, thus running the risk of creating a de facto two-tier system. Similarly, federal subsidies for deductibles and co-payments will be available only for deductible and co-payment amounts that exceed the "low cost sharing" levels; thus, even the poorest Americans will face some cost sharing, including \$10 per doctor visit and \$5 per prescription. While few would argue with the principle of encouraging personal responsibility, this burden will have its most telling effect on pregnant and postpartum women, infants, and those with chronic or complicated illnesses, because they will need frequent care and multiple medications.

Some of the many potentially serious problems that could be faced by low income Americans and the working poor in a managed competition-based system include -

- Severely Restricted Choice of Plans or Providers: Because of the restricted subsidies, individuals with family incomes below 150% of the Federal poverty level are unlikely to be able to afford the premium surcharges for higher-cost plans. By this standard, 60 million people -- 25% of the entire population -- will be able to choose only among the lowest-cost plans, and will be subject to the discrimination and poor quality often associated with the Medicaid program. It is unclear whether or to what extent low-income and other medically vulnerable populations will be assisted to enroll in plans, select a plan that works best for them, and to obtain the care and services they need, which in many cases go beyond the care and services included in the required package and furnished by traditional plans.
- Lack of Plan Capacity: Those who can afford only a basic plan may find there are not enough such plans available with enough capacity. Few plans will be willing to market coverage at the premium charged by basic plans, and will instead target employer-insured families.

- Increased Discrimination and 'Redlining': Due especially to the inadequate financing, health plans will have every incentive to avoid areas with high numbers of low-income people. Fly-by-night plans will be the only providers bidding for coverage in these low income-areas – resulting in diminished access and lower quality services for all enrollees there. Depending on how Alliance and plan service areas are delineated major redlining could occur, with low-income, racial and ethnic minorities, and at-risk populations gerrymandered into segregated Alliance and plan service areas and subject to less oversight and poor quality care. The experience with redlining under Federal voting rights and credit lending laws suggests that no duty not to redline can counteract wide discretion in drawing identifiable service areas.
- Obstacles to Specialty Care: Lower-cost plans are more likely to require stricter utilization review and place more obstacles between low-income patients and specialty care. In particular, persons with chronic illnesses or disabilities may be adversely affected if plans are permitted to severely restrict out-of-plan referrals or payment for specialized care and services. Also, plans will presumably be required to cover out-of-area services (at least for emergency/ urgent care needs). However, it is not clear yet how this will work under the President's plan. This is a critically important issue for migrant farm workers, transportation employees and others whose work requires frequent and extensive travel, and involves multiple employers.
- Inadequate Monitoring of Quality and Access: Based on the experience with Medicaid, states and Alliances may not be able to adequately monitor quality and access in low-cost plans, especially when faced with the pressing need to hold down the cost of care.

Simply put, underserved Americans are in the health care predicament they are in because they have been rejected by the private market. Thus, if market forces work for health care like they have worked in other sectors of the economy, underserved people and communities run the risk of being red-lined, short-changed and, in the end, getting far less care than they need or deserve.

In addition, the Clinton plan places heavy reliance on states to administer the new program, and states are given considerable flexibility in doing so, or in opting out to run their own independent program. Unchecked state flexibility could mean a substantially diminished role for Federal laws and programs for disadvantaged and underserved Americans that were crafted to respond to the inability or unwillingness of states to address these problems in the past. The current Medicaid program provides an instructive example of what can happen if consistent federal rules are lacking or are not fully enforced; and the plans recently put forth by states such as Oregon and Tennessee underscore the potential dangers for disadvantaged, minority, and underserved people that could accompany the lack of consistent national standards under health reform.

Finally, undocumented persons will be barred from public subsidies and from receiving employer-subsidized benefits (thus disqualifying millions from the employer coverage they now have). All hospitals presumably would still be required to furnish emergency care to undocumented persons under Federal anti-dumping law, but potentially hundreds of millions – if not billions – of dollars in uncompensated care would remain, with as yet no clearly identified Federal funding to cover the cost.

These concerns underscore the critical need for a substantial, Federally-administered "safety net" for millions of disadvantaged and underserved Americans, even after reform is implemented. The Health Security Act acknowledges this principle, but its response falls critically short on several counts. For example:

- **Access to Care:** the Health Security Act's Access Initiative calls for an investment of about \$1 billion in the expansion of primary care services in underserved areas, in assisting in the formation of service delivery networks, and in furnishing key 'enabling services,' such as transportation and translation services, to those living there. However, this new investment would be offset by reductions in funding for existing programs -- beginning with \$180 million in 1996 and rising to \$650 million by 1998, including \$300 million from the health center programs and millions more from the Family Planning, Maternal and Child Health Block Grant and Ryan White AIDS programs -- thus reducing the *net* new investment to less than \$400 million, or *about \$10 for every underserved American*, at its highest point.

Nearly all of the funds would be administered under a *totally new, discretionary program*, which would target its resources to a wide variety of organizations, including for-profit HMOs, private doctors and private health plans, with little or no community involvement or accountability; resources would not be targeted to underserved communities directly.

Further, the discretionary construct of this new program raises the distinct possibility that existing programs, such as the health centers, Family Planning, MCH, and Ryan White, which will continue to fill vitally important purposes even after reform is implemented, will be pitted against the new program for scarce federal resources -- even after the Act's proposed offsets take effect. Senators Fritz Hollings and Tom Harkin have fought harder than almost any other Member of this institution for funding for these programs, yet have been unable to keep their funding on par with general inflation, much less health inflation. A discretionary funding construct for a health reform access initiative -- with creation of a totally new, duplicative program notwithstanding -- essentially assures that funding levels for these programs will never be adequate.

Members of this august Committee must consider: if this program is enacted in its current form, who will be around to pick up the pieces when this well-intentioned, but incredibly naive and ill-informed policy fails?

- **Essential Community Providers:** The Health Security Act recognizes those who currently care for the underserved (such as community, migrant and homeless health centers, family planning clinics, and Maternal and Child Health clinics) as "essential community providers" (ECPs), and extends certain rights, such as contracting and payment requirements, for the first five years after reform begins.

All Health Plans are **required** to contract with ECPs in their service area. ECPs that elect to contract on an "in-plan" basis (most health centers are likely to do this) will be paid no less than other providers for the same services by the Plan. This does not account for the **inherently higher costs of treating high volumes of underserved, at-risk patients.**

ECPs that contract on an "out-of-plan" basis (most likely, school-based clinics, health care for the homeless, etc.) will be paid based on the Alliance-developed fee schedule or the most closely applicable Medicare methodology (for a health center, FQHC cost-based reimbursement), at the ECP's choice. The problem here is that **patients who go to an "out-of-plan" provider are subjected to a minimum 20% cost sharing requirement – pricing many low-income, disadvantaged patients out of this option altogether, and therefore making it effectively infeasible for an ECP to choose.**

ECPs also get precious few safeguards from risk-based contracting by health plans. A likely scenario under the Health Security Act: the health plan gives the mandatory contract to the ECP, but on a risk basis; the health plan assigns the ECP the sickest patients, and pays the ECP no less – but no more – than other providers for the same services, with the ECP at risk for any costs in excess of the health plan's capitated payment. The ECP is out of business in 2-3 years.

NACHC feels one overriding policy should govern the construct of an Essential Community Provider initiative: those providing comprehensive primary care services in underserved areas should be paid an adequate rate, and should be exposed to minimal risk. A goal of the Health Security Act is for more caregivers to provide primary care, especially where it is most needed, and for more of the underserved to receive primary care and preventive services. Unfortunately, the current structure of the Essential Community Provider provisions of the Act basically guarantee that that goal will go unmet.

- **Health Professions Education and Placement:** Under the Health Security Act, the nation's medical schools and teaching hospitals – which have played no small role in the current oversupply of specialists and our critical shortage of primary care physicians – would continue to be the principal beneficiaries of a \$6 billion entitlement in the President's plan, an "additional payment" for the specialized care they provide, as well as the lion's share of a separate \$6 billion pot to fund Graduate Medical Education costs.

Community health centers with teaching programs have produced hundreds of family physicians, general internists and general pediatricians -- exactly the kinds of doctors our health system desperately needs -- yet they get nothing in the way of funding to continue or expand their educational efforts in the President's plan. Currently health centers with teaching programs are required to affiliate with a sponsoring medical school or teaching hospital. Payment for the costs of the health center's educational program is made on a "pass-through" basis with the sponsoring institution. The result is that many "teaching health centers" end up eating a substantial portion of the costs of their educational efforts. Further, the availability of residency opportunities in community and migrant health centers is directly linked to the availability of teaching hospitals willing to engage in educational partnerships with them.

We'd like to have direct access to medical education funds so we can provide practice opportunities for medical residents and expose more medical students to the benefits of providing primary care in an underserved area. The available literature shows that where medical residents are exposed to primary care training in a community-based setting, significant numbers enter primary care as a practice. For the health system envisioned under the Health Security Act to function, it will have to generate significant numbers of new primary care physicians. Community and migrant health centers anxiously await the opportunity to participate in those physicians' education.

Making Health Reform Work for Underserved Americans

We believe that, if health reform is to work for underserved communities, it must empower medically underserved communities to develop workable, permanent, responsive community health care systems, through steps to:

- provide a substantial investment of guaranteed resources to develop community-based health care networks and health plans, and to continue and increase support for key programs that now provide vital services to disadvantaged and underserved populations (including the health center programs, Family Planning, and others);
- strengthened safeguards for Essential Community Providers that assure preservation of the existing safety net in underserved communities, and their full participation in the new health care system;
- assure the participation of ECPs in health professions education and training and provide for payment to cover the cost of their involvement, to guarantee adequate supply of primary care educational opportunities for medical students in the most appropriate settings.

The most pressing need of -- and the most rational response to -- the medically underserved under any health care reform approach is increased availability of community-responsive, comprehensive primary health care services, particularly under a market-driven approach to reform where the bottom line will take absolute precedence. Yet more can and should be done than just investing in service development: the lesson of the health center programs is that, although it may not be possible to empower communities to take control of the entire new health system, it is possible to empower them to own and operate their own entry points into it. Even with their great successes, however, health centers are currently able to reach only 15% of the 43 million medically underserved Americans who need access to community-based primary care services. Health centers were founded with a vision of community and consumer empowerment, and their experience over the past 30 years provides an object lesson on how consumer involvement and community empowerment can succeed where other models have failed. In this sense, health centers may be the last, best hope for communities in shaping their health care system and making it responsive to their needs. For obvious reasons, we strongly believe that any access initiative worthy of the name should retain and significantly expand upon the health center model because:

- o it is a proven model of getting Federal funds to improve the health of hard-to-reach populations to the areas that need them most;
- o health centers represent a multibillion dollar investment by the Federal government in primary care infrastructure in underserved communities over the last 30 years, and are the only entities that have attracted and retained health professionals in shortage areas;
- o health centers have proven their effectiveness, cost efficiency and quality of care over the past 30 years;
- o it is a proven model of empowering underserved communities to control their own points of access into the health system, and to tailor the services provided by the center to the unique needs of the community;
- o the centers' consumer governing boards are accountable for efficient utilization of Federal funds and quality of services provided, and health centers are subject to strict monitoring and oversight by Federal agencies, unparalleled in the private sector.

Policymakers should look hard at what has worked and why, and what has not worked for the underserved:

- o Who has provided culturally competent care and ACCESS to these communities? Who has not?

- o Who have seen all regardless of the ability to pay? Who has not?
- o Who has kept costs in check while developing innovative approaches to meeting the health needs of these communities? Who has not?
- o Who has attracted, trained and kept physicians and qualified health professionals in underserved communities? Who has not?
- o Who has genuinely empowered communities to develop long-range solutions to their health care needs? Who has not?

Thus, we firmly believe that health reform should build on what has worked, by calling for a substantial new investment in health centers --

- o as the President's original plan proposed;
- o as last year's Democratic Senate Leadership Bill proposed;
- o as the House and Senate Republican Health Reform bills propose;
- o as the single-payer bill (S. 491/H.R. 1200) proposes.

We are asking the President not to compromise on his pledge to make ACCESS as important as cost containment, and to make health reform work for the current system's outcasts. Build health empowerment systems with a new investment in the Community Health Center program to meet the needs of all underserved communities.

Members of Congress can and must make sure that health care reform "stays on track" and works for our Communities. Congress knows what works and should renew its commitment to Community Health Care. This is not about a program, but rather an approach to empower communities to develop and direct long range solutions that will work for them.

In summary:

- President Clinton made a commitment to equality of access to health care. We fully support that pledge, and believe that health care reform should work for all Americans, and especially for the medically underserved.
- There is much to admire and support in the President's proposed plan; at the same time, some elements cause considerable concern about how well the plan will address the most pressing needs of underserved Americans.
- Health care costs will never be controlled unless high-risk, underserved populations have access to primary and preventive care. Access to health insurance does not necessarily mean access to health services.
- Health care reform should build on what has worked: the community, migrant and homeless health center programs. Nothing else has our uniquely successful, 30-year track record of controlling costs, providing access to quality care, retaining health professionals where they're most needed, or empowering communities to develop long-range solutions to their health needs. Health reform should invest in such successes.
- We are committed to support and work with the President and the Congress to ensure the earliest possible passage and enactment of an effective, comprehensive national health reform plan.

Thank you.

Mr. WAXMAN. Mr. Gage.

STATEMENT OF LARRY S. GAGE

Mr. GAGE. Thank you very much, Mr. Chairman. I have submitted my statement for the record.

NAPH includes over 100 of America's metropolitan area safety net hospitals. We were gratified to hear those hospitals referred to this morning by members of the subcommittee on both sides of the aisle. These hospitals provide over 70 percent of their services to Medicaid and low-income uninsured and underinsured patients. They train a substantial proportion of our Nation's doctors, nurses and other health professionals, and they often serve as the only provider of many costly specialized services that you have heard talked about this morning, such as trauma care, burn care, neonatal intensive care, high risk pregnancy services, emergency psychiatric services, and the like.

Our prepared testimony does comment extensively on various provisions of the Health Security Act, including medical education, but I will focus briefly on the concept and issue of essential community provider here.

NAPH member hospitals have for many years served as essential providers in their respective urban communities. We endorse the major principles of the Health Security Act; however, we are concerned that managed competition may prove ineffective for many years in meeting the needs of many inner cities. In many such areas, the playing field is not currently level, either for providers or patients. To a certain extent the administration recognizes this and includes in its plan several provisions related to essential community providers; however, we are concerned that hospitals, while they are eligible to apply to be designated ECP's, they are not granted automatic designations, such as several other categories of providers enjoy. We believe it is essential that any statutory definition provide for automatic designation, at least of certain hospitals.

We are going to release a new 170 page special report tomorrow, which we believe illustrates the growing crisis facing these hospitals and the patients they serve. Let me give you one or two facts from that report, and copies of the report have been made available to members of the subcommittee.

Between 1980 and 1990, low-income patients were increasingly concentrated in just a small handful of inner city hospitals. Public general hospitals saw increased Medicaid utilization of 43.5 percent and public university hospitals over 39 percent during that period, and the proportion of self-pay for uninsured patients also increased nearly 17 percent while dropping in most other hospitals.

In the hundred largest cities the use of inner city hospital emergency rooms and outpatient departments increased by nearly 40 percent between 1980 and 1990 to over 100 million visits. But the importance of designating hospitals as ECPs is grounded in their services for their entire communities, not just the poor.

In conclusion, I have attached to my testimony two recent news stories that graphically illustrate this community wide mission, and I have provided two charts as visual aids. One of these stories, dated only last Tuesday, and headlined "A Tidal Wave of Walking

Wounded," describes the extraordinary services provided to thousands of California earthquake victims by the hospitals of the Los Angeles County health system and the Olive View Medical Center particularly. The photograph accompanying the article shows trauma physicians treating row after row of emergency patients spread out across the hospital's parking lot.

The second story, dated January 7, is headlined, "Girl Beats Odds After Devastating Ski-Run Accident." It describes Brooke Sebold, a 12-year-old girl. The daughter of a Texas physician, Brooke, was brought by air ambulance from Vail, Colo., to the State's only Level I adult trauma center at Denver Trauma Hospital. She had a severely lacerated liver, other multiple injuries, had lost most of her blood and faced a low chance of survival. Two weeks later, Brooke walked out of Denver General after a remarkable team of 20 physicians saved her life.

The point of these stories is that even if health insurance is available to pay for the specific care provided to Brooke Sebold and many of the California earthquake victims, it is highly unlikely that the President's plan, or any of the other reforms being proposed, will subsidize the substantial standby costs to make sure that essential systems and services are going to be available when they are needed.

And these cases are not isolated or unique. We have seen many other recent examples of the need for such standby services, from Hurricane Andrew to the Midwest floods to the World Trade Center bombing to the Los Angeles riots to the measles epidemic in Milwaukee in which a substantial majority of the unimmunized children who were hospitalized were already members of Medicaid-managed plans.

In conclusion, let me say NAPH agrees that many parts of our health system today are not functioning properly and need to be restructured or reformed, but in doing so it is essential to understand that we have relied heavily for many years on a fragile network of safety net institutions to fill in the huge gaps in our system. This reliance will continue into the foreseeable future as we phase in universal health coverage.

Mr. WAXMAN. Thank you very much, Mr. Gage. Appreciate that testimony.

[Testimony resumes on p. 344.]

[The prepared statement of Mr. Gage follows:]

N A P H

**Statement of Larry S. Gage
President**

National Association of Public Hospitals

before the

**Subcommittee on Health & The Environment
Committee on Energy & Commerce
U.S. House of Representatives
Washington D.C.
January 25, 1994**

Mr. Chairman, Members of the Subcommittee, I am Larry Gage, President of the National Association of Public Hospitals (NAPH). NAPH's members include over 100 of America's metropolitan area safety net hospitals. These 100 institutions (taken together) comprise America's most important health and hospital system. With combined revenues of almost \$16 billion, these hospitals provide over 71% of their services to Medicaid and low income uninsured and underinsured patients. In other words, these hospitals already serve as "national health insurance" by default in most of our nation's urban areas. At the same time, these hospitals train a substantial proportion of our nation's doctors, nurses, and other health professionals. They also often serve as the only provider of many costly, specialized services, such as trauma care, burn care, neo-natal intensive care, high risk pregnancy services, and emergency psychiatric care.

I am pleased to have this opportunity to testify before the Committee on national health reform generally, and on the importance of "essential community providers" in particular.

Our nation's failure to provide universal, mandatory health coverage has long been the single most glaring deficiency of our nation's health system -- one we share only with South Africa among Western nations. NAPH members believe that President Bill Clinton has offered Americans our best opportunity in over half a century to join the family of civilized nations that make adequate health care a basic right of citizenship. NAPH strongly supports President Clinton in this historic effort. NAPH members are unanimously committed to working with the President -- and with the members of this Committee -- to achieve enactment of universal, mandatory health coverage as swiftly as possible. We simply cannot afford to let this opportunity slip away, like so many others in the last 50 years.



NAPH member hospitals have for many years served as the most "essential" providers in their respective urban communities, playing this role despite facing many fiscal and administrative obstacles over the years. The situation of many of these urban safety net hospitals continues to worsen today, even as the significance of their community wide services continue to be emphasized by recent events. The nation's urban public hospitals continue to be burdened by multiple crises -- including persistent state and local budget shortfalls -- escalating federal and state curbs on Medicaid eligibility and spending -- continuing increases in the number of uninsured and under-insured -- and an increasing inability or unwillingness of many providers to shift uncompensated costs to privately insured patients.

In just two days, Mr. Chairman, NAPH will release a new 170 page Special Report on the crisis facing urban safety net hospitals in America today. Let me illustrate the urgency of this situation with a few facts from that new Report (copies of which have been provided for the members of the Subcommittee):

Safety net hospitals today are bursting at the seams, with an extraordinary volume of inpatient and outpatient care. 60 NAPH member hospitals across the nation averaged over 270,000 emergency room and outpatient visits and 14,000 admissions, and totalled 17.3 million emergency and outpatient visits, in 1991. Despite overcapacity in many parts of the hospital industry, NAPH members averaged a 79% occupancy rate in 1991, almost 27% greater than the overall average for hospitals in the 100 largest cities for 1990.

Between 1980 and 1990, low income patients were increasingly concentrated in just a small handful of inner city hospitals. Public general hospitals saw an increased Medicaid utilization during this period of 43.5%, and the increase in public university hospitals was over 39%, compared with *reduced* Medicaid utilization in private university hospitals of nearly 14%. The proportion of self pay patients also increased nearly 17% in urban public hospitals between 1980 and 1990, as compared with decreases of 16-41% in all other categories of hospitals.

In the largest 100 cities in the 1980s, the use of inner city hospital emergency rooms and outpatient departments increased by over 39% between 1980 and 1990, to nearly 100 million visits. Urban public hospitals represent just 7.4% of all hospitals but provided 18% of outpatient care and 19% of emergency care in 1990.

Some of the largest urban public hospitals provide a staggering volume of emergency and outpatient care that could be provided in a more appropriate setting if one were available. For example, Atlanta's Grady Memorial Hospital provided nearly 865,000 emergency and outpatient visits in 1990; Cook County Hospital, over 670,000; Los Angeles County+USC Medical Center nearly 645,000. Urban public hospitals in the northeast experienced the highest average volume of outpatient and emergency hospital care, with an average of 413,000 visits in 1990.

Emergency and clinic patients are waiting longer to see doctors or be admitted. 58% of NAPH hospitals reported periodic waits by emergency department patients of 12 hours or more for admission, and half of all hospitals surveyed reported that some patients were forced to wait more than 24 hours.

Safety net hospitals continue to concentrate their services on low income patients - serving as both hospital and family doctor for the uninsured. In 1991, 24% of all discharges and 20% of all inpatient days in NAPH member hospitals were not sponsored even by Medicaid. 37% of all outpatient and emergency room visits were also by uninsured patients.

Safety net hospitals also continue to be uniquely reliant on governmental funding sources. Just 12% of the gross revenues of safety net hospitals were derived from private insurance and 16% from Medicare in 1991, while 71% were attributable to Medicaid and "self pay" patients. Average gross revenues at NAPH member hospitals were \$92 million for Medicaid patients and \$78 million for self pay patients (who are typically uninsured and thus - "financed" only by direct local governmental subsidies and other mechanisms such as Medicare and Medicaid disproportionate share hospital adjustments).

In other words, carrying out their missions of serving the poor and providing essential community-wide services, NAPH member hospitals would have lost \$3.2 billion dollars in 1991 without local taxpayer subsidies and Medicaid "disproportionate share hospital" (DSH) payments. Such payments enabled these hospitals to break even and keep their doors open; yet both sources of financing have come under pressure from federal, state, and local governments in recent years. 67 NAPH members surveyed had total revenues of \$12.2 billion and total expenses of \$12.4 billion. They would have experienced significant losses, however, if not for local taxpayer subsidies of \$2.1 billion. In addition, we estimate that these hospitals received net Medicaid DSH payments totalling approximately \$1.4 billion based on an analysis of 1992 DSH data. On average, surveyed hospitals relied on Medicaid DSH payments for 12 percent of their total revenue.

As a result of this funding crisis, the many community-wide services provided by safety net hospitals are in danger of deterioration as well. Trauma centers, high risk obstetric units, emergency psychiatric units, emergency drug abuse treatment programs, burn centers, neonatal intensive care units -- all are overflowing, at a time when state and local budget crises often require reductions, not increases, in funding.

In short, while Congress debates how to improve coverage and access to care, these safety net hospitals are providing that care now -- to more and sicker people, and at substantially greater uncompensated cost -- than at any other time in our nation's history. For all of these reasons, NAPH believes that enactment of universal health coverage must now be our most important domestic policy priority.

NAPH believes that President Clinton's proposal is an excellent foundation for achieving health reform -- one which meets most of the principles NAPH has laid out in the past in testimony before this Committee as a prerequisite to our support for any plan. While other proposals -- such as a broad-based single payer system -- could also possibly satisfy NAPH's principles, we find much to admire in the President's plan, including:

- its commitment to universal and mandatory coverage, without which a "health plan" would be little more than tinkering around the edges of our current system rather than a genuine reform,
- its commitment to prevention and primary care in the context of a generous uniform benefit package,
- its proposal to community rate premiums for all, as well as to adjust premiums to reflect such factors as health and income status,
- its willingness to subsidize premiums for low income individuals and small businesses, and
- its willingness to pay attention to the special access and infrastructure needs of providers in underserved areas and academic health centers.

At the same time, NAPH does have a number of concerns about the Clinton plan, including its definition and treatment of "essential community providers". In the remainder of my testimony, I will describe these concerns in greater detail and suggest a number of issues and questions for you to consider in your forthcoming deliberations.

NAPH's primary concerns are in the following areas:

- the extent to which hospitals will be included in the definition of "essential community provider" under the plan, and the level and scope of support for such providers under a system of "managed competition,"
- the treatment of certain populations excluded under the plan, such as illegal immigrants and prisoners,
- the possibility that the President's plan may call for the elimination or reduction of Medicare and Medicaid disproportionate share hospital adjustments, which finance a broad range of essential services in many underserved areas,
- the impact of health reform on the ability of essential safety net hospitals to obtain the capital they need to rebuild their infrastructure and assure continued access in many urban and rural areas, and

· the impact on safety net providers of the dramatic changes proposed for our nation's medical education system.

The remainder of my prepared testimony will briefly describe our questions and concerns in each of these areas.

1. WITH RESPECT TO THE CONCEPT OF "ESSENTIAL COMMUNITY PROVIDER", NAPH STRONGLY RECOMMENDS THAT HOSPITALS AS WELL AS CLINICS (AND OTHER FEDERAL GRANTEES) BE DESIGNATED ESSENTIAL COMMUNITY PROVIDERS, IN ORDER TO ENSURE CONTINUED ACCESS FOR LOW INCOME PATIENTS WHO RELY ON THESE PROVIDERS AND CONTINUED AVAILABILITY OF THEIR COMMUNITY-WIDE SERVICES.

NAPH accepts the concept of managed competition in principal and believes it can be given an opportunity to work wherever feasible. However, based on our extensive experience serving the urban uninsured, we are concerned that managed competition may prove ineffective for many years in meeting the needs of some areas, including inner cities and isolated rural areas. We believe this is true for several reasons, including the lack of a sufficient number and variety of plans and providers to guarantee access and choice even for individuals who have been issued their "card", and the checkered history of efforts to introduce competitive models to such areas (such as the California PHP scandals of the early 1970s and the Florida scandals of the 1980s).

It must be recognized, in implementing "managed competition", that the playing field is not currently level for either providers or patients in the inner cities and remote rural areas. To be equitable, and to guarantee access for patients in such areas to the broadest range of health and social services, a plan must ensure that all safety net providers (including public hospitals that currently serve a high volume of low income patients, as well as health centers and other federal grantees) are automatically determined to be ECPs and given the opportunity to participate in (and be paid by) all plans serving these patients.

In that regard, Administration includes in its plan the designation of certain providers as "essential community providers" (ECP), and provides additional support and assistance to the providers so designated (including the guarantee that they will be paid for services rendered to enrollees of all plans in underserved areas). While hospitals are eligible to apply to the Secretary to be designated ECPs, they are not granted the automatic designation granted to several other categories of providers. **NAPH believes it is essential that any statutory definition of ECP provide for automatic designation of certain hospitals as well as health centers and other providers.** For your information, I have attached to my testimony a copy of a position paper provided to the Administration early last year on this subject. Included in this paper are suggestions for a number of criteria that might be written into the statute in order to carefully target any automatic designation of hospitals as ECPs, including criteria already used in the past by this Committee in areas such as Medicaid drug pricing and the requirement under Section 1923(b) that all states designate, at a minimum, the

highest volume providers of Medicaid and low income care as "disproportionate share hospitals".

It must be made clear that the importance of designating certain hospitals as ECPs extends to the services they provide to their entire communities, not just the poor. In that regard, I have taken the liberty to attach to my testimony two recent news stories that graphically illustrate this essential community-wide mission.

One of these, dated only last Tuesday and headlined "A Tidal Wave of the Walking Wounded", refers to the extraordinary services provided to thousands of California earthquake victims by the hospitals of the Los Angeles County health system generally, and the County's Olive View Medical Center in particular. A photograph accompanying the article shows trauma physicians treating row after row of emergency patients spread out across the hospital's parking lot.

The second of these, dated January 7, is headlined "Girl Beats Odds After Devastating Ski Accident". It describes Brooke Sebold, a 12 year old girl, the daughter of a Texas physician, who was brought by air ambulance from Vail, Colorado to the state's only Level I trauma center at Denver General Hospital, with severely lacerated liver, other multiple injuries, and a less than 5% chance of survival. Two weeks later, Brooke walked out of Denver General, after a remarkable team of 20 physicians saved her life.

The point of each of these cases is that even if health insurance is available to pay for the specific care provided to Brooke Sebold and many of the earthquake victims, we believe it is highly unlikely that the President's plan -- or any of the other reforms being proposed -- will adequately pay the substantial standby costs of making sure the essential systems and services are going to be available when they are needed. And these cases are not isolated or unique. In just the last year or two we have seen many other examples of the need to preserve such standby services, from Hurricane Andrew to the Midwest floods to the World Trade Center bombing to the Los Angeles riots. Behind these headlines you will find many other, perhaps less dramatic, health crises around the country that require the response of a health safety net -- such as the measles epidemic in Milwaukee in which over two thirds of the hundreds of unimmunized children hospitals were in fact members of Medicaid managed care plans.

Finally, with respect to ECP status, I would also like to point out that this is an area in which we have worked closely for many months with the Rural Health Association, the National Association of Community Health Centers, and other groups, and in which there is agreement among these various groups on the automatic designation of certain hospitals as ECPs. In turn, NAPH supports the additional safeguards and authorizations in amendments to health reform that are currently under development by NACHC, and that may be submitted as a separate piece of legislation.

The remainder of my testimony will describe a number of other NAPH concerns and recommendations with respect to health reform generally, and the Clinton plan in particular.

2. HEALTH REFORM MUST NOT BE FINANCED THROUGH ELIMINATION OR SUBSTANTIAL REDUCTION IN DISPROPORTIONATE SHARE HOSPITAL PAYMENTS UNLESS OTHER PROTECTIONS AND PAYMENTS ARE SUBSTITUTED FOR THE HIGHEST VOLUME PROVIDERS OF CARE TO OUR MOST VULNERABLE POPULATIONS.

NAPH strongly supports a broad array of financing mechanisms for universal health coverage, including taxes on excess employee health coverage, so-called "sin taxes" on alcohol and tobacco, sliding scale cost sharing for higher income insured individuals, and increased Medicare cost sharing. We would also support a tax cap on the deductibility of premiums by both corporations and individuals.

NAPH's most serious concern in the areas of financing has to do with the apparent proposal to finance a substantial part of health reform through Medicare and Medicaid reductions generally, and through elimination of the so-called "disproportionate share hospital" (DSH) adjustments in particular. The DSH adjustments -- which this Committee has played a major role in enacting and improving over the years -- have been of great importance in helping safety net hospitals provide the broad range of additional services needed by low income patients and urban (and remote rural) communities.

With respect to Medicare, since the Medicare program will remain largely outside of health reform, we believe the Medicare DSH adjustment should remain intact. We further recommend that Medicare DSH payments be strengthened for the very highest volume DSH providers (especially if there is an elimination or substantial reduction in Medicare graduate medical education funding, as is also proposed).

With respect to Medicaid, NAPH acknowledges that there have been numerous instances where states have used DSH funds for other than their intended purpose, and that with the phase-in of universal coverage this adjustment is unlikely to be preserved in its current form. However, it is important to point out that there are also many states which have not treated Medicaid DSH adjustments as a scam or a new form of revenue sharing -- which have used the adjustment as it was intended to be used, to fund substantial additional programs and services to Medicaid recipients and the uninsured poor. New data collected by NAPH and provided to Subcommittee staff shows, for example, that 100 of the highest volume providers of care to Medicaid patients and the uninsured collected over \$2 billion in net Medicaid DSH payments in 1992. These payments were essential to their ability to keep their doors open and preserve access for both insured and uninsured patients in many underserved urban areas.

NAPH therefore strongly recommends that Medicaid DSH be carefully phased out, not terminated abruptly, if universal mandatory coverage is enacted, with residual

DSH payments targeted on the highest volume providers of care to the poor. Moreover, even if Medicaid DSH is carefully phased out, as noted in the previous section of my testimony, many residual community-wide public health and social services will continue to be needed even after most uninsured Americans have been given their "card". For these reasons, NAPH strongly supports the inclusion of the "vulnerable population" adjustment proposed in the Clinton plan, although our research and analysis indicate that this adjustment should be in the range of \$3 billion nationally rather than the \$800 million currently allocated.

3. NAPH IS CONCERNED ABOUT THE PROVISION AND FUNDING OF SERVICES FOR MANY INDIVIDUALS WE CURRENTLY SERVE WHO MAY NOT BE ELIGIBLE -- OR WHO MAY FACE SIGNIFICANT BARRIERS TO ENROLLMENT - - UNDER THE PRESIDENT'S PLAN.

One of NAPH's most important principles is that national health reform must be nothing less than **universal and mandatory for all residents**. While the President's plan has expressed the goal of universality, and appears to be mandatory for those who are eligible, NAPH is especially concerned that there are certain populations who will continue to fall through the cracks -- either intentionally or unintentionally -- and that there are other potential barriers to enrollment that, if not adequately understood and addressed, will have the same effect as being ineligible for coverage in the first place.

Two populations likely to be excluded from coverage that have generated considerable discussion to date are illegal immigrants and prisoners. NAPH members and other urban public hospitals serve a very substantially disproportionate number of both populations and will be especially hard hit if they remain wholly outside the system.

With respect to illegal immigrants, the vast majority of health care currently accessible to this population is in urban and rural safety net hospitals and clinics. This care is funded by a precarious patchwork of federal, state and local funding, augmented by cost shifting wherever possible. Recent federal programs such as SLIAG, which was targeted at legal (not illegal) immigrants, have in the past been able to pay for some of these services. However, most such funding has now been reduced or terminated, and House efforts this summer to add more money to the budget reconciliation bill failed. Unless either coverage or funding is made available in health reform, the potential exists for the situation of the population to become far worse. With the expressed goal of "converting" Medicaid and other current revenue sources into premium income for those populations who will receive coverage, it is likely that there will be far less ability in the future even than there is in already inadequately funded system today to pay for the care that will continue to be needed by this large population. We cannot make illegal immigrants -- or their health needs -- simply disappear by refusing to cover them under health reform. We must make some sort of provision for their care if we are to have a truly unified system.

With respect to prisoners, the issue is equally complex. Prisoners are today excluded from Medicaid coverage and denied many other rights. Their care is sometimes paid for by

the criminal justice system that incarcerated them, sometimes by state or local governments through other means, and sometimes the cost of their care is simply absorbed by the public hospital that treats them. Because it is an unfortunate fact that many prisoners today come from segments of the population that had not previously been eligible for health coverage, the problem in the past has perhaps been less obvious and less troubling than it will be after health reform. In the future, however, all prisoners who are legal residents will theoretically have been eligible for coverage prior to their incarceration, and will again become eligible following their discharge. And while safety, security and the needs of the criminal justice system require simplicity in any health system, there is no logic to maintaining prisoners outside the new nationwide system if our goals are universality, cost containment through prevention and earlier treatment, and the broadest possible sharing of risk. While mainstreaming prisoners in alliances and plans may be impractical, clearly the entire system will benefit if targeted plans, perhaps backed by a nationwide risk pool, can be developed for prisoners.

In addition to immigrants and prisoners, NAPH is also concerned about other populations that may fall through the gaps or be unable or unwilling to enroll under health reform even if eligible. These populations include the homeless and the deinstitutionalized mentally ill.

As our experience with Medicaid demonstrates, there may be other significant barriers to enrollment even for many individuals who may otherwise be eligible -- especially in inner cities and isolated rural areas. In fact, given the complexity of the system and the need for cost sharing by all but the poorest enrollees, it is virtually guaranteed that many people will simply not sign up for a health plan, even if it is considered mandatory. Rather, they will present themselves to providers in the future as they do today -- sick or injured, addicted or mentally ill, homeless, often unable to provide us with basic information about themselves. Our experience also tells us that some inner city residents will actually sign up for multiple plans, either inadvertently or intentionally, or may conceal their previous enrollment in order to obtain care at a more convenient or familiar location. For these reasons, it is therefore imperative that the eligibility process be kept as simple as possible, that the additional costs to providers of treating and enrolling certain populations be taken into account, that providers must be able to rely on the presumptive eligibility of any individual who shows up in their emergency room, that careful outreach and patient education be provided, and that new systems include maximum protections against patient misunderstanding or abuse.

In addition, NAPH applauds the concept of a "risk adjusted" premium for plans to take into account the special needs of individuals with more serious illnesses, injuries, conditions, or personal situations (including income status). However, we are concerned that the development of such an adjustment may be complex and take longer than envisioned, and that many alliances and plans may well become fully operational well before such an adjustment is in place. In addition, we are concerned that the President appears to propose only that a risk adjustment factor be added to plan premiums, with no additional requirements or assurances that "risk-adjusted" payments also be made to those providers who will treat

disproportionate numbers of those patients determined to be at risk of greater needs and higher costs.

Also of concern is the possibility of adverse selection and "targeted marketing" by some plans -- cream-skimming, if you will -- that will leave the sickest and the poorest to enroll in "public plans". NAPH believes that there must be substantial safeguards, including mandatory open enrollment, limitations on advertising, and mandatory random assignment of "high risk" patients. Both tough rules and strict enforcement -- including criminal penalties -- must be included.

4. THOUGH ADEQUATELY COMPREHENSIVE IN MOST RESPECTS, THE PROPOSED BENEFIT PACKAGE WILL RESULT IN MANY UNCOVERED COSTS FOR SOME URBAN RESIDENTS WHO SUFFER FROM ALCOHOLISM, DRUG ABUSE OR MENTAL ILLNESS.

NAPH is please that the basic benefit package provides an **emphasis on (and in most cases, first dollar coverage for) primary and preventive care**. We also agree that it appears generous and adequate in most cases.

Our two major concerns with the contents of the benefit package are with the proposed limitations on mental health and substance abuse benefits. We are extremely concerned that, while these limitations may make good policy sense for healthy, educated, employed middle class Americans, they fail to address the much greater needs of many residents of our nations inner cities. For many individuals, these diseases are primary, not secondary, diagnoses, and substantial barriers to effective functioning. Left untreated, they have substantial implications for the quality of life of all urban residents, significantly increasing (for example) the likelihood of crime and violence in our nation's inner cities.

NAPH is also concerned with reports that some categories among currently eligible Medicaid populations -- and especially poor women and children who are eligible for Medicaid but not AFDC or SSI payments -- may lose many of the additional benefits they now receive.

5. IT IS ESSENTIAL THAT ANY MAJOR SHIFT IN THE FUNDING OF MEDICAL EDUCATION TAKE INTO ACCOUNT THE SPECIAL NEEDS OF SAFETY NET HOSPITALS AND UNDERSERVED PATIENTS.

NAPH strongly supports the need to develop more rational and broad-based funding mechanisms for medical education, and to shift our emphasis in medical education (as well as in patient care) away from specialization and towards primary care and prevention.

Because most NAPH member hospitals are major teaching hospitals, and rely on their medical education programs for both education and patient care, we have several concerns with certain ambiguities in the President's proposal, as follows:

- Major urban public teaching hospitals must be eligible to be designated academic health science centers or "affiliated hospitals" of such centers.
- With the reduction in specialty residencies, the criteria for allocation of such residencies in the future must include a clear reference to the importance of patient care as well as educational needs.
- In the shift away from specialty residencies, attention must be given to the fact that there are still many parts of the country -- such as inner cities and remote rural areas - where there remain severe shortages in many medical specialties.
- Where a residency program encompasses several different and unrelated centers or hospitals, clear criteria must be spelled out for allocating the proposed medical education funding and ensuring an equitable apportionment among all major components of the program.
- The impact of health reform on the training of allied health professionals and on the ability to improve the proportion of minorities in all health professions must also clearly be taken into account in any such sweeping reform of our medical education system.
- The new system must also be carefully phased in over a period of time, and transitional funding must be available to affected hospitals and health centers whose teaching programs will be reduced or changed.

6. FINALLY, IN ORDER TO ASSURE ADEQUATE ACCESS AND A CAREFUL TRANSITION TO A NEW SYSTEM, SOME URBAN AND RURAL SAFETY NET PROVIDERS WILL REQUIRE ASSISTANCE IN GAINING ACCESS TO CAPITAL TO REBUILD THEIR INFRASTRUCTURE AND DEVELOP NEW NETWORKS AND PLANS.

Many supporters of various national health reform proposals have suggested that, if reforms were enacted, there would no longer be a need for an institutional health safety net. We can only note that the same thing was said about the enactment of Medicare and Medicaid. Given the strong likelihood that future changes will continue to be incremental and piecemeal, NAPH believes that there will continue to be a strong need for the public health safety net in our nation's metropolitan areas.

We must thus be extremely careful about dislodging any current institutional funding mechanisms for public health systems in general, and safety net hospitals in particular, unless we are certain that we have a workable and fully implemented system to take their place. Moreover, we must continue to press forward with more targeted programs and reforms that support "stand by" health and social services and safety net providers.

For example, essential urban and rural safety net hospitals are likely to face a substantial need for assistance under health reform in obtaining adequate capital to rebuild and equip our nation's health infrastructure. A 1993 NAPH study estimates that there are at least \$15 billion in unmet capital needs among these essential urban providers. Yet these hospitals also face significant barriers in obtaining access to capital, as well as in their ability to repay incurred debts entirely from patient care revenues. In order to meet these needs, a new Federal capital financing initiative is clearly needed. NAPH has assisted with the drafting of a major new urban/rural capital financing initiative that was first introduced in 1992, and was reintroduced last year in both the House and the Senate. While its cost to the federal government would be only \$1 billion per year, this bill would create federal-state-local and public-private partnerships to finance up to \$15 billion in capital improvements for safety net hospitals, through loan guarantees, interest rate subsidies and grants to meet both general and specific safety net capital needs.

In addition to capital needs, there are other areas in which infrastructure and "enabling services" must be funded to ensure a smooth transition to universal coverage. For example, it is important that funding be made available to improve the ability of urban and rural safety net providers to develop and finance regional provider networks that include a full range of services, including ambulatory and preventive care in addition to acute inpatient care, and to participate as effectively as possible in managed care programs and initiatives. It is also essential that the many health and social programs and services currently provided by public hospitals and public health departments be continued, and that the implementation of health reform not be permitted to diminish or reduce support for these programs and services.

In conclusion, for many reasons, even if national health insurance were adopted this year, America's safety net institutions will need continued support well into the future:

- Any new health reform system is likely to be phased in over a long period of time.
- Even with coverage, many of our current uninsured will be little better off than Medicaid patients, who today find their access restricted in many states to those "open door" hospitals and clinics who will serve them.
- Many of the currently uninsured and underinsured also suffer from a variety of health and social problems very different from those of middle America. Conditions such as AIDS, substance abuse, tuberculosis, and teenage pregnancies are often augmented by homelessness, joblessness, and lack of education. While no health care provider can fully cope with all of these problems, in many areas, our urban safety net hospitals are the only ones even trying to do so today.
- In addition, many safety net hospitals are simply located in the geographic areas where most of our uninsured Americans reside -- areas which, even if national

health coverage were fully implemented, most other health care providers will continue to be unwilling or unable to serve.

Finally, with the dramatic cost containment efforts already being imposed by both public and private payers, we must recognize that many expensive and unprofitable community-wide "standby" services (such as burn care, and neonatal intensive care, and the emergency and trauma services provided by Denver General, Los Angeles County and many of their counterparts around the country) are already under pressure and in danger of being reduced or eliminated in some areas; unless they are taken into account in health reform, the result will be a significant reduction in the security and health status of all of our citizens, not just the uninsured poor.

It is clear that there are many parts of our health system today that are not functioning properly, that need to be restructured or reformed. But it is essential to understand that we have relied heavily for many years on a fragile network of safety net institutions to fill in the huge gaps in our system, and this reliance will continue into the future even as we phase in universal health coverage. In other words, we have a network of unique hospitals in our nation today who have always been ready, willing and able to serve as "providers of last resort" -- to keep their doors open and their services accessible to all persons, regardless of race, creed, income, or insurance status. If the federal government generally, and this Committee in particular, are not willing to adequately support the existence of this "provider of last resort" capacity, it is clear that no one else will do so either, and this capacity will disappear.

I would be pleased to answer any questions you may have at this time.

Defining "Essential Community Provider"

Concern has been expressed in the development of proposals for health system reform about maintaining and improving access for low income patients to essential medical, public health and social services in underserved urban and rural areas. In many such areas, it is increasingly clear that neither traditional nor innovative new forms of insurance coverage will by themselves guarantee the availability of needed services -- either to many individuals or to the community as a whole.

For this reason, it has been suggested that certain types of health care providers be designated for special attention in underserved inner cities and remote rural areas. Such attention may include assistance in developing multi-provider community health networks, gaining access to needed capital to rebuild or expand primary and acute care capacity in underserved areas, participating in Health Alliances and Affordable Health Plans, and being eligible for continued, targeted payment rates or adjustments even after health reform is fully phased in, to take into account the special services provided and special needs of low income populations.

The purpose of this memorandum is to suggest the key elements that must be taken into account in defining such "essential community providers", and to direct attention to certain existing definitions in federal law that may be adapted or cross referenced in the health reform proposal.

At the outset, it is important to emphasize that **the number and proportion of providers to be designated should not be vast or open-ended. Rather, needed support can be carefully targeted on those providers that meet truly essential community needs.**

Nor is it necessary to reinvent the wheel in defining these providers. Several definitions already exist in federal law, such as the Federally Qualified Health Center (FQHC), Essential Access Community Hospital (EACH), 1992 Medicaid Drug Pricing exceptions legislation, and high volume Medicare and Medicaid "disproportionate share hospital" (DSH) definitions. It will be a relatively simple matter to adapt or cross-reference these definitions for the purposes of health reform legislation.

Key elements to be taken into account in any definition of "essential community provider" are as follows: (please note that it may not be necessary for all of these elements to be met for a provider to qualify as an "ECP")

1. **Such providers should provide a relatively high volume or proportion of their services to low income patients.** Currently, this test is relatively simple to quantify for both community health centers and hospitals. CHCs are by law required to serve all within their service area who seek care regardless of insurance coverage or ability to pay; and they must employ an income-based system of discounting charges to low income uninsured patients. With respect to hospitals, both Medicare and Medicaid recognize such providers, in their definitions of hospitals that qualify for "disproportionate share hospital" (DSH) adjustments. Assuming it is intended that the Medicare program remain intact, the Medicare definition can be used. However, since over 1500 hospitals qualify for Medicare DSH it is necessary to further limit this element of any definition to the "highest volume" providers. In order to do so, it may be helpful to limit designation to those high volume public and private Medicare DSH hospitals as defined last fall without an ownership requirement for Medicaid drug pricing (PL 102-585). No more than 500 hospitals would be covered with this definition. It is important to emphasize that the Medicare DSH formula, while it does target most of the relevant hospitals, has proved inadequate in states (like Texas) where Medicaid eligibility has been historically low. In such states, under the "Pickle amendment", the extent of direct local subsidies for low income patients has been used as a surrogate. This element should

be preserved. The Medicaid statute also includes a baseline of high volume DSHs that must be included by any state (although states are free to expand beyond this definition). Finally, if the Medicaid program itself is to be phased out or merged into a larger public plan, the proportion of low income patients served by a hospital under the public plan should be substituted for Medicaid in the formula. Note that it is important that a provider qualify on the basis of the low income status of its patients rather than where it is physically located, since some providers in both urban and rural areas serve low income patients from a broad geographic area.

2. **To qualify, a provider should demonstrate some form of "public" ownership, operation, assistance, financing or mission.** Such a showing can be demonstrated by falling into one of several preexisting federal categories, such as FQHC, FQHC look-alike, EACH, sole community hospital, family planning clinic, etc., or by an independent showing, such as in the Medicaid drug pricing legislation passed in 1992 or federal capital financing legislation recently reintroduced as S. 726. In that legislation, to be eligible, hospitals or health centers must be owned, operated or (if they are non-profit hospitals) must be at least partially financed by direct federal, state or local subsidies. About 200 hospitals and 700 health centers meet this definition. Broader inclusion of non-profit hospitals may be considered desirable as long as they can demonstrate that they fulfill a "public (or community) health mission" by meeting the "low income service" and/or "community needs" definitions.

3. **The definition can also include providers on the basis of the essential community services they provide.** Such services may range from primary and preventive health services, on the one hand, to a carefully defined array of specialized acute and emergency services that must be available on a 24 hour stand by basis. Examples of specialized acute medical community, primary or public health services may include social workers, family planning, translators, outreach, transportation, etc. Examples of specialized services may include Level I trauma centers, burn centers, neonatal intensive care and pediatric intensive care units, high risk pregnancy service, emergency psychiatric services, and emergency medical services (such as air and ground ambulance).

4. You may also want to consider designating certain other providers categorically as ECPs. Examples might include governmentally owned hospitals that are already part of broader health systems or public health departments, hospitals or clinics that provide a significant volume of services to patients who will continue to be gap populations (such as undocumented immigrants), the children's hospitals, or hospitals with an extremely high volume or proportion of low income patients (e.g., over 50% combined Medicaid and other low income patients).

5. Finally, other indicators that you may wish to consider in defining "essential community providers" may include evidence of financial distress or continued high unreimbursed costs (but demonstrably necessary), willingness to enter into local or regional community health networks, and the willingness to submit to determinations of need for new, renovated, or expanded services or technology.

Mr. WAXMAN. Mr. Gallegos.

STATEMENT OF JOE GALLEGOS

Mr. GALLEGOS. Mr. Chairman, members of the committee, as President of the New Mexico Primary Care Association, I represent a coalition of primary care clinics and community health centers in New Mexico, representing 48 primary care sites.

Also, I am Executive Director of Health Centers of Northern New Mexico, a nonprofit organization that has been in operation since 1972 consisting of a network of 11 primary care clinic sites and one dental practice. These centers are strategically located throughout a 20,000 square mile area located in health professional shortage and medically underserved rural communities in northern New Mexico.

It is indeed an honor and pleasure for me to come to discuss an issue of such major importance to each of you and every American: Our health care and our well-being. Of equal importance is that we have come together to participate in the design of a health care system which will be better than the one we have now.

My comments today will focus on President Clinton's proposal as it pertains to essential community providers who serve disadvantaged groups in underserved areas. Because I come from a rural State like New Mexico, my comments are directed at concerns for health care delivery in rural areas in New Mexico and rural America.

President Clinton and Congress are to be applauded for the commitment and courage to take on the health care reform issue and for drawing a clear line on critical issues such as universal coverage and elimination of exclusions on preexisting conditions. Thankfully, the plan recognizes the key role of essential community providers such as community health centers. Sadly, however, after a modest first-year investment in essential provider infrastructure, the plan calls for major disinvestment in community-based providers with funds then redirected to investment in for-profit and institutional providers. This will result in serious financial and geographical access to essential primary and preventive health care. We must ensure that universal access equates with financial and geographical access.

As a representative of a rural community health center, approximately 65 percent of its registered patients have no health insurance or are underinsured, I am deeply concerned that the plan lacks a commitment to community-based primary care clinics. For example, in New Mexico, the fifth largest State in the union, 25 percent of the population, or approximately 400,000 citizens, lack health insurance or are underinsured.

Outside of Albuquerque, Santa Fe, and Las Cruces, the remaining area of the State is rural. The density of the population in some counties ranges from 10 persons per square mile to less than 1 person per square mile.

It is my firm belief that providers such as community health centers and other health clinics that have committed themselves to serving rural residents, uninsured, and otherwise vulnerable populations, which the current system consistently ignored, deserve better treatment than that being offered by the Clinton plan.

In terms of access, amendments to the Health Security Act should be amended whereby under current provisions of the Health Security Act, preference will be given to private practices and large institutions and for-profit providers for grants to develop networks and alliances to serve rural populations.

The current nonprofit community-based providers who presently provide the major access to New Mexico's poor and rural residents are to be consumed by these large providers or fade out of existence. Because non-profit community-based clinics provide the major access to New Mexico's poor and rural residents, these programs should be targeted for expansion rather than those who have ignored the poor or underserved, in terms of infrastructure development, replacement of medical-dental equipment in target facilities for modernization.

In New Mexico, we have seen little investment by major health plans in rural communities. A number of communities have been literally abandoned by institutional providers because of downturns in the economy.

Among rural New Mexicans, there is a real intensified fear that once institutional community providers have been consumed or eliminated, rural areas will again be shortchanged and ignored as health plans concentrate on the more profitable densely populated urban areas.

There is little evidence of managed competition success in rural areas, particularly in States with the cultural diversity and poverty characteristics of New Mexico and other rural States.

Community-based clinics on the other hand have a proven track record, having served as a safety net for vulnerable populations that major health care plans have excluded due to patients' lack of financial resources, geographical isolation, cultural and linguistic characteristics, and high-risk health and chronic conditions.

Without essential community providers in rural America, a major gap in services will result.

The Health Security Act recognizes essential community providers and requires mandatory contracting in the early years of health care reform. However, it does not offer essential community providers any protection from the increased cost of serving high-risk populations.

HMO's and institutional insurers have long recognized this risk and sought to avoid covering high-risk individuals and vulnerable populations. If essential community providers must accept the same payment that managed care providers offer to care for healthier and more affluent insured individuals, nonprofit clinics would be forced to cut back on essential services or jeopardize their ability to survive.

Ironically, HMO's have continued to profit from the practice of avoiding high-risk populations, a practice that must not continue.

In summary, I would just ask the Congress and policy-makers to ask themselves the policy questions as who has provided culturally competent care and access to rural America and who has not; who has seen all patients regardless of their ability to pay, who has not; who has kept costs in check while developing innovative approaches to meeting the health care needs of rural America, who has not; who has attracted, trained and kept physicians and quali-

fied health professionals in underserved communities, who has not; who has genuinely empowered rural America to develop long-range solutions for their health care needs, who has not?

You will find that the health—community health center model provides all of those alternatives.

Thank you.

Mr. WAXMAN. Thank you very much.

[The prepared statement of Mr. Gallegos follows:]

STATEMENT OF JOE GALLEGOS

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

My name is Joe Gallegos. I am President of the New Mexico Primary Care Association, a coalition of primary care clinics in New Mexico consisting of 18 members, representing 48 primary care clinics. I am Executive Director of Health Centers of Northern New Mexico, a non-profit organization with a 25 member community-based volunteer Board of Directors. Health Centers of Northern New Mexico has been in operation providing primary care since 1972 and consists of a network of eleven primary care clinic sites and one dental practice. These clinics are strategically located throughout a 20,000 square mile area located in Health Professional Shortage Areas (HPSA) and Medically Underserved rural communities in Northern New Mexico. My professional background includes over 16 years experience in health care administration and health planning in New Mexico.

It is indeed an honor and a pleasure for me to come before you to discuss an issue of such major importance to each of you and to every American; **our health care and our well-being.** Of equal importance is that we have come together today to participate in the design of a health care system which will be better than the one we have now.

My comments today will focus on President Clinton's proposal as it pertains to **"essential community providers"** who serve disadvantaged groups in underserved areas, whether in rural and remote communities or in inner cities. Because I come from a rural

State like New Mexico, my comments are directed at concerns for health care delivery in rural areas in New Mexico and rural America.

President Clinton and Congress are to be applauded for the commitment and courage to take on the health care reform issue and for drawing a clear line on critical issues such as universal coverage and elimination of exclusions on preexisting conditions. Thankfully, the plan recognizes the key role of "essential community providers" such as community health centers. Sadly, however, after a modest first year investment in essential provider infrastructure, the plan calls for major disinvestment in community-based providers with funds then redirected to investment in for-profit and institutional providers. This will result in serious financial and geographical access to essential primary and preventive health care. We must ensure that universal access equates with financial and geographical access.

As a representative of a rural community health center, approximately 65% of its registered patients have no health insurance or are underinsured; I am deeply concerned that the plan lacks a commitment to community-based primary care clinics. For example, in New Mexico, the 5th largest state in the nation; 25% of the population (approximately 400,000 citizens) lack health insurance or are underinsured. Outside of Albuquerque, Santa Fe and Las Cruces, the remaining area of the state is rural. The density of the population in some counties range from 10.74 persons per square mile to less than one person per square mile. In addition, the community health center which I represent contains

five out of the top ten counties in the State with the largest percentage of families living below the federal poverty level. It is my firm belief that providers such as community health centers and other health clinics that have committed themselves to serving rural residents, uninsured and otherwise vulnerable populations, (which the current system consistently ignored) deserve better treatment than that being offered by the Clinton Plan.

The following amendments to the Health Security Act (HSA) would better serve the citizens of New Mexico as well as vulnerable populations across the country:

ACCESS: Under current provisions of the Health Security Act, preference will be given to private practices and large institutions and for-profit providers for grants to develop networks and alliances to serve rural populations. The current non-profit community based providers who presently provide the major access to New Mexico's poor and rural residents are to be consumed by these large providers or fade out of existence. Because non-profit community-based clinics provide the major access to New Mexico's poor and rural residents, those programs should be targeted for expansion rather than those who have ignored the poor and underserved.

In the past, in New Mexico we have seen little investment by the major health plans in rural communities. A number of rural communities have been literally abandoned by institutional providers after downturns in the economy. Among rural New Mexicans there is a real and justified fear that once the essential

community providers have been consumed or eliminated, rural areas will again be short-changed and ignored, as health plans concentrate on the more profitable, densely populated urban areas.

There is little evidence of managed competition success in rural areas, particularly in states with the cultural diversity and poverty characteristics of New Mexico and other rural states. Community based clinics, on the other hand have a proven track record, having served as a "safety net" for vulnerable populations that major health care plans have excluded due to patients' lack of financial resources, geographical isolation, cultural and linguistic characteristics and high risk health and chronic conditions. Without essential community providers in rural America, a major gap in services will result. Major health plans are not likely to move to rural areas to provide health care under a managed competition model due to a sparse population base. There will remain the need for maintaining and expanding the present infrastructure and developing new infrastructure in rural areas where none exist. We must maintain and expand community based clinics in rural areas to increase their capacity to meet community demand; increase funding for infrastructure development, replacement of medical/dental equipment and target facilities for modernization, elimination of safety hazards and repair or replace obsolete facilities through loans or guarantees.

REIMBURSEMENT OF ESSENTIAL COMMUNITY PROVIDERS: The Health Security Act recognizes essential community providers and requires mandatory contracting in the early years of health reform.

However, it does not offer essential community providers any protection from the increased costs of serving high risk populations. HMO's and Institutional Insurers have long recognized this risk and sought to avoid covering high risk individuals and vulnerable populations.

If essential community providers must accept the same payment that Managed Care Providers offer for the care of their healthier, more affluent insured individuals, non-profit clinics will be forced to cut back on essential services or jeopardize their ability to survive. Ironically, HMO's will continue to profit from the practice of avoiding high risk populations; a practice that must not continue.

The Health Security Act should be amended to assure essential community providers a reasonable payment rate through some type of gap coverage mechanism such as that used in other rural states like Wisconsin and Minnesota in which essential community providers are not put at undue risk. Such provision would require each health plan, as a condition of certification, to contract with all certified essential community providers located in its service area. Each essential community provider must elect to contract either as a participating (in-plan) provider under terms no less favorable than for other providers regarding payment, risk assignment, incentives, and patients assigned. Alternatively, each essential community provider may elect to contract as an out-of-plan provider without gate-keeping restrictions, and with payment at Medicare rates or at rates established by an alliance-developed fee schedule. Strong safeguards must be stipulated as "most

favorable treatment" of essential community providers as in-plan contractors by establishing a federal **Community Health Security Payment** for FQHCs and other essential community providers that wish to participate to compensate for lack of risk adjustment. This payment would flow directly to FQHCs to cover shortfalls between reasonable costs and health plan payments. For example, a maternal and child health program in New Mexico will reimburse prenatal care providers at higher rates depending on risk factors present in the pregnant woman.

HEALTH PROFESSIONS TRAINING: Community based health centers have been active training grounds for family physicians in training at the undergraduate and residency levels. As a result, community health centers have incurred unreimbursed training expenses in the hope that exposure to underserved community programs will be a long-range recruitment tool. Meanwhile, medical schools and teaching hospitals, who are responsible for the shortage of primary care physicians, have enriched themselves through direct and indirect graduate medical education payments.

The Health Security Act perpetuates this inequity through unreasonable restrictive regulations. It should be amended to encourage and reimburse community based clinics for participating in the medical education system.

In summary, I strongly urge Congress and the Clinton administration to look hard at what has worked and why, and what has not worked for the underserved. Questions must be asked by policy makers, and as you ask these questions; I am certain you

will find the answer to be - the community health center model.

* Who has provided culturally competent care and ACCESS to rural America? Who has not?

* Who has seen all patients regardless of their ability to pay? Who has not?

* Who has kept costs in check while developing innovative approaches to meet the health needs of rural America? Who has not?

* Who has attracted, trained and kept physicians and qualified health professionals in underserved communities? Who has not?

* Who has genuinely empowered rural America to develop long-range solutions to their health care needs? Who has not?

Again, thank you for the opportunity to meet with you today.

STATEMENT OF DONALD D. TRUNKEY

Mr. WAXMAN. Dr. Trunkey.

Mr. TRUNKEY. Mr. Chairman, members of the subcommittee, I am Dr. Donald Trunkey, Chairman of the Department of Surgery at Oregon Health Sciences University Hospital in Portland, Oreg. I am also a past chairman, Committee on Trauma of the American College of Surgeons and a founding member of the board of trustees of the Coalition for American Trauma Care.

Oregon Health Sciences University Hospital is an academic health center, contains a children's hospital. It is a public institution and most importantly for today's hearing, is a level 1 trauma center. The coalition has worked closely with the subcommittee on other important legislation recognizing the cost benefit of regionalized trauma systems of care which is established in policy and legislation, many of the principles we believe should be preserved in a reformed health care system.

Our specific comments on the President's Health Security Act are included in our written testimony.

I would first like to state for the record that the coalition genuinely applauds President Clinton and First Lady Hillary Rodham Clinton for their leadership in bringing this very important but very difficult and complex issue before the American people and the Congress.

There is much in the President's bill that the coalition can and will strongly support. I want to place the issue of injury and the work of our coalition and other factions of the trauma care community in an appropriate context.

Injury is the leading cause of death for Americans from birth through age 44. For every death, there are at least three to four permanent disabilities. Injury is the leading cause of years of lost productivity, more than cancer and heart disease combined.

Since it affects the young and the work force, it is our most costly disease, estimated at \$180 billion in lifetime costs in 1988. In my opinion, injury is the Nation's most important public health and social issue.

The coalition has worked to address this public health problem on many fronts. This includes community-based injury awareness and prevention efforts and university-based injury research programs. Unfortunately, even in the most public—perfect public health model, injury can never be entirely prevented.

Thus, we must focus on mitigating the consequences of injury to the greatest extent possible. Trauma systems of care are designed to provide cost effective secondary and tertiary and prevention services so that when serious injury does occur, death and disability are prevented.

When disability cannot be fully prevented, then every effort is made to restore as much function as possible. The coalition believes strongly that organized regional systems of trauma care are a model of reform of costly specialized tertiary care services.

The regional and State programs that have been established in the United States go through a very rigid professional and quality assurance process.

A State trauma system must address at least six critical components. The first is prevention. The short and long-term strategies

to identify root causes of behavioral and societal factors that result in unintentional and intentional injury must be identified and implemented.

A second component is access to the trauma system. This means 911, availability and public awareness and education to act quickly so that individuals with life-threatening injury can immediately access to expert care.

The third component a prehospital care, emphasizing trained personnel who provide the initial resuscitation and transport by ambulance, fixed-wing and rotor-wing aircraft.

The fourth essential component is triage or transfer decision making. Not all trauma patients need the expertise of a trauma center. The intent is to concentrate the critically injured in a few centers, thus reducing costs while maintaining the skill level of the physicians and nurses who provide care for critically injured individuals.

The fifth trauma system component is acute hospital care, specialized trauma care facilities where experienced surgeons and nurses and other health professionals provide 24-hour resuscitation and lifesaving surgery every day of the year.

And finally, rehabilitation. Rehabilitation is started within hours of the lifesaving surgery. The goal is to return all injured patients to lives as productive members of society.

Organized regional systems of trauma care are a cost proven effective public health solution to a major public health problem. Americans expect and want safe water to drink and clean air to breathe. Americans also expect and want an environment safe from injury and a government prepared to implement primary prevention measures.

But if primary prevention fails, Americans want a health care system that will save an injured loved one when death is truly preventable, a health care system that will prevent unnecessary disability, and a health care system that will provide the services that can make their family members productive again.

The coalition is aware of instances in many States and regions of States, even those with fully developed trauma care systems, where some third party payers currently refuse appropriate transfer to a trauma center. This is unfortunate.

I hasten to add for the record that there are many payers that specifically contract with trauma centers throughout the country. These would include trauma centers in Boston, Denver, Colo., areas of Pennsylvania, Ohio, Minnesota, Detroit, Washington, D.C., and my own institution in Portland, Oreg.

We need to provide an appropriate and positive environment for the growth and development of model managed care which is extremely cost effective when the total costs are accessed.

Thank you, sir.

Mr. WAXMAN. Thank you very much, Dr. Trunkey.

[Testimony resumes on p. 374.]

[The prepared statement of Dr. Trunkey follows:]

STATEMENT OF DONALD D. TRUNKEY

Mr. Chairman, and Members of the Subcommittee, I am Dr. Donald Trunkey, Chairman of the Department of Surgery at University Hospital in Portland, Oregon. I am also a past Chairman of the Committee on Trauma of the American College of Surgeons and a Founding Member of the Board of Trustees of the Coalition for American Trauma Care. University Hospital is an academic health center, contains a children's hospital, is a public institution and most importantly for today's hearing, is a Level I Trauma Center.

On behalf of the membership of the Coalition for American Trauma Care, I want to thank you for providing our organization an opportunity to testify before the Subcommittee on the vitally important issue of health care reform and how trauma care relates to this reform.

The Coalition for American Trauma Care is a national, not-for-profit organization whose membership includes physician directors of trauma care, leading trauma center institutions, and national organizations with a commitment to improving the delivery of trauma care services to seriously injured individuals and a strong commitment to injury prevention. The mission and goals of the Coalition are to improve trauma care services to seriously injured individuals through universal implementation of organized regional systems of trauma care, through improved basic and clinical trauma related research, through improved reimbursement for trauma center institutions, and to improve injury prevention activities at all levels of government.

The Coalition has worked closely with this Subcommittee on re-authorization of the *Trauma Care Systems Planning and Development Act* (P.L. 101-590), on enactment of the trauma center grant program to assist trauma centers fiscally stressed due to drug related violence (Title VI, P.L. 102-321), on enactment of the trauma provisions in legislation re-authorizing the National Institutes of Health which will develop a national plan for basic and clinical trauma care research (P.L. 103-43), and in support of the newly established Center for Injury Prevention and Control and the Centers for Disease Control and Prevention.

The Coalition is now pleased to comment on *The Health Security Act*, President Clinton's plan to reform the nation's health care system.

I would first like to state, for the record, that the Coalition genuinely applauds President Clinton and First Lady Hillary Rodham Clinton for their leadership in bringing this very important, but very difficult and complex issue, before the American people and the Congress. There is much in the President's bill that the Coalition can, and will, strongly support.

But before I discuss specific provisions in the bill, I want to place the issue of injury and the work of our Coalition and other factions of the trauma care community in an appropriate context.

Injury is the leading cause of death for Americans from birth through age 44. For every death there are at least three to four permanent disabilities. Injury is also the leading cause of years of lost productivity -- more than cancer and heart disease combined. Since it affects the young and the workforce, it is our most costly disease -- estimated at \$180 billion in lifetime costs in 1988. In my opinion, injury is the nation's most important public health and social issue.

The Coalition has worked to address this public health problem on many fronts. This includes community-based injury awareness and prevention efforts and university-based injury research programs. Unfortunately, even in the most effective public health models of prevention, injury can never be entirely prevented. Thus we must focus on mitigating the consequences of injury to the greatest extent possible. The Coalition, and other members of the trauma community, have promoted organized, regional systems of trauma care which are designed to provide *cost-effective* secondary and tertiary prevention services so that when serious injury does occur, death and disability are prevented. When disability cannot be fully prevented, then every effort is made to restore as much function as possible.

The Coalition believes strongly that organized, regional systems of trauma care are a model of reform of costly, specialized, tertiary care services. The regional and state programs that have been established in the United States go through a rigid professional and quality assurance process.

The first step in establishing a trauma system is to determine need. This is done in conjunction with state officials, health policy experts, and public input. Basing the trauma system on need limits the number of specialized centers that will be established within a

region. **The next step** is to enact enabling legislation authorizing the state, or other entity, to establish the trauma system which includes designating trauma centers. **The third step** is to use professionally established guidelines of care in designing all components of the trauma system.

Once these steps have been taken, the authorized entity -- usually the state emergency medical service agency -- typically then allows all hospitals to participate in the designation process, recognizing that only a few will be chosen based on need, including geographic considerations, and ability to meet professional guidelines. The applications are reviewed and verified on-site by a professional review team, ideally comprised of individuals from outside of the state. Hospitals that are chosen and verified to provide trauma care services are then formally designated by the authorized state entity.

The final step is to institute ongoing needs assessment and quality assurance. This is extremely important since numerous studies document sharp reductions in preventable death rates immediately following implementation of a trauma system with even further reductions achieved in years thereafter. One recent study of workman's compensation cases showed states with implemented trauma systems achieved significant direct and indirect cost savings when compared with states without trauma systems. Quality assurance studies show that the vast majority of even the most severely injured individuals, when provided with timely, qualified trauma care, return to work, household, or school activities full time within one year of injury.

A state trauma system must address at least six critical components: **1) prevention** -- short and long-term strategies to identify root causes of behavioral and societal factors that result in unintentional and intentional injury must be identified and implemented; **2) access to the trauma system** -- this means 911 availability and public awareness and education to act quickly so that individuals with life-threatening injury get immediate access to expert care; **3) pre-hospital care** -- trained personnel who provide the initial resuscitation and transport by ambulance, fixed-wing, or rotor-wing aircraft; **4) triage, transfer decision-making** -- triage is a French word which means "to sort." Not all trauma patients need the expertise of a trauma center. The intent is to concentrate the critically injured in a few centers thus reducing costs while maintaining the skill level of the physician and nurses who provide care for critically injured individuals; **5) acute hospital care** -- specialized trauma care facilities where experienced surgeons and nurses and other health professionals provide 24 hour resuscitation and lifesaving surgery every day of the year; **6) rehabilitation** -- rehabilitation is started

within hours of the lifesaving surgery. The goal is to return all injured patients to lives as productive members of society.

Trauma centers are also uniquely organized to care for the seriously injured patient. The regional trauma center (Level I) has five main components: **1) pre-hospital medical control** -- pre-hospital personnel at the injury scene consult hospital-based physicians with trauma expertise and receive triage and life support direction; **2) emergency department** -- 24 hour, in-house availability of a specialized team of physicians, nurses, and other personnel that is mobilized to assess and treat seriously injured individuals upon arrival at the emergency room door; **3) operating room** -- immediate operating room availability 24 hours per day and availability of multiple surgical specialists to manage multiple life-threatening injuries simultaneously; **4) intensive care unit** -- availability of multidisciplinary state-of-the-art intensive care services coordinated by the trauma surgeon thus eliminating the need for multiple and fragmented specialty consultation; **5) rehabilitation** -- early integration of rehabilitation assessment and services during the initial acute care admission with the goal of returning the patient to his or her pre-injury level of functioning.

The trauma patient requires both an organized pre-hospital response and an organized acute care and rehabilitation response to achieve the most cost-effective outcome. This is because the trauma patient, especially the individual with multi-system involvement, requires immediate, coordinated, multidisciplinary care all available in one location. This may be best illustrated by describing a multiply-injured patient. A typical example might be an individual involved in a motor vehicle crash who sustains a severe head injury (intracranial hematoma), a torn major artery (torn thoracic aorta), massive liver injury, and unstable pelvic (hip) fracture. Clearly, this individual needs immediate and simultaneous attention by those trained in neurosurgery, general surgery with trauma expertise, and orthopedic surgery, as well as expert nursing care, rehabilitation assessment and services, and specialized x-ray, and other equipment. These specialized, and very expensive, services should be concentrated in just a few hospitals to ensure they are utilized in the most cost-effective fashion possible and to ensure that professional skills are maintained. The designation of qualified trauma centers, with these characteristics, form the backbone of the trauma system.

Organized, regional systems of trauma care are a proven, cost-effective public health solution to a major public health problem. Americans expect and want safe water to drink

and clean air to breathe. Americans also expect and want an environment safe from injury and a government prepared to implement primary prevention measures. But if primary prevention fails, Americans want a health care system that will save an injured loved one when death is truly preventable; a health care system that will prevent completely unnecessary disability; and a health care system that will provide the services that can make their family members productive again.

It is in the context of this public health model that the Coalition for American Trauma Care assesses the provisions of the *Health Security Act*.¹

GENERAL COMMENTS

Availability of Qualified Trauma Care

While the various components of an organized, regional system of trauma care are covered under the benefit package there is no acknowledgement throughout the bill that serious injury, as a major public health problem, requires a system of care approach because of its time-sensitive nature and treatment. In addition, except for academic health centers, it is left to the discretion of states whether or not to require health plans to contract with centers of excellence, or other specialty care centers. The Coalition acknowledges that there is considerable overlap between academic health centers and qualified² trauma centers, but not all qualified trauma centers are teaching hospitals, or operate approved physician training programs. States often rely upon these trauma centers, usually Level II institutions, to serve major segments of their populations, particularly in smaller cities, and rural areas. The Coalition would like language added to the state responsibility section which requires health plans to contract with a qualified trauma center. The justification for this added requirement is, again, due to the unique time-sensitive nature of serious injury and the need for timely, specialized intervention which meets specific standards of care to achieve a cost-effective outcome for a major, costly public health problem.

At the same time, to facilitate the pre-hospital component of trauma care systems, it is essential that provisions in the *Act* requiring health plans to pay for medically necessary emergency medical services wherever they occur are retained in the bill. The latter should

¹ For the pages that follow, the "Act" denotes the Clinton Health Security Act.

² A qualified trauma center is a designated trauma center as defined under Title XII of the U.S. Public Health Service Act, and/or as verified by the American College of Surgeons. Such qualified trauma centers, as defined, also include pediatric trauma centers.

be construed to include ground and air ambulance transport as well as hospital based emergency and trauma care services.

The Coalition is aware of instances in many states and regions of states, even those with fully developed trauma care systems, where some third party payers currently refuse appropriate transfer to a trauma center for patients subsequently determined by community hospital physicians to require the services of a qualified trauma center. Other payers have inappropriately placed financial pressures on family members for premature transfer out of the trauma center. These concerns can and should be corrected in health system reform by applying uniform treatment standards for reimbursement for qualified trauma care services.

I hasten to add, for the record, that there are many payers that specifically contract with trauma centers throughout the country. Examples include trauma centers in Boston, Denver, Colorado, areas of Pennsylvania, Ohio, Minnesota, Detroit, Washington, D.C., at my own institution in Portland, Oregon and in many other areas where there are qualified trauma centers. We need to provide an appropriate and positive environment for the growth and development of model managed trauma care which is extremely cost-effective when the total costs of care are assessed.

Regionalization of Trauma Care

It is also important to note that many trauma centers are truly regional in nature and serve seriously injured individuals from several states. The *Act's* provisions restricting health alliances to state boundaries could interfere with the interstate triaging process for seriously injured individuals that now takes place in many areas of the country. States sometimes even designate a trauma center that is in another state. This practice should be acknowledged in the state responsibility section. States should require health plans to contract with qualified trauma centers, which may include state designated trauma centers located within another state.

The Coalition would like to see Title III of the Act, under the public health initiatives, include \$20 million in funding for trauma system development as provided by the *Trauma Care Systems Planning and Development Act*. This is the minimum amount needed to fully implement the provisions of the legislation and will do much to further trauma system development. Currently, while there are qualified trauma centers in almost every state only half of the states have developed organized systems of trauma care. Requiring

health plans to contract with qualified trauma centers will provide strong incentives to states to develop trauma systems; providing financial support for doing so under the Trauma Systems Act will also enhance this desirable result.

We would certainly hope that the Subcommittee would support this request since it is your leadership, Mr. Chairman, with the bi-partisan support of the Members of this Subcommittee, that resulted in the enactment of this landmark legislation supporting trauma system development. It is truly making a difference in the lives of thousands of Americans. In fact, as you may be aware, the House Republican health reform bill, H.R. 3080, incorporates the provisions of the *Trauma Care System Planning and Development Act* and authorizes \$60 million for the program, which is a great tribute to the work of this Subcommittee.

Reimbursement for Trauma Care

Finally, the Coalition feels strongly that health care reform must provide universal access to health care for the nation's uninsured in a fashion that is timed to precede, or coincide with reductions in the Medicare and Medicaid programs, as proposed under the *Health Security Act*. If the cuts precede coverage many more trauma centers may close their doors. Since 1985, over 100 trauma centers have closed across the country. Some of these closures are due to improved standards, which is a positive development. But almost all others, especially the eleven Level I trauma centers that have closed in major urban areas, have closed due to the fiscal stress caused by chronic under-reimbursement often exacerbated by outbreaks of drug-related violence.

Many officials in the Clinton Administration, including the President himself, have said to us, "Under the Clinton health plan trauma centers will finally get relief from the burdens of uncompensated care because the uninsured will be covered." We respond, honestly, that it depends. It depends on two factors: 1) that universal coverage proceed in concert with and not after the implementation of further cuts in Medicare and Medicaid; and 2) that health plans be required to contract with qualified trauma centers. It does not help the fiscal crisis facing the nation's trauma centers if the uninsured are eventually covered, but the hospital has already closed its trauma center because Medicaid and Medicare disproportionate share support and other Medicare reimbursement were significantly reduced first. Nor does it help if the trauma center survives these fiscal challenges, but health plans do not contract with it and refuse appropriate transfers to the trauma center or apply pressure for premature discharge from the trauma center. Under these

conditions, unfortunately, we predict further trauma center closures, and further compromise of the American public's access to the life-saving services of qualified trauma centers.

OTHER COMMENTS

Coverage

While we appreciate the difficult cost considerations that led to excluding undocumented aliens from coverage under the Clinton health plan, we do not agree with this exclusion. Seriously injured individuals are admitted to the hospital and treated regardless of their ability to pay. In some areas of the country, especially along the Mexican-U.S. border, trauma centers are in serious fiscal crisis because of the great influx of undocumented aliens, a number of whom need qualified trauma care services.

Benefit Package

The *Act's* comprehensive benefit package includes most of the components of a trauma system, but the Coalition would like the following specific change. The language limiting use of air and water ambulance transport only to those instances where any other method of transport would be contra-indicated by the medical condition of the sick or injured individual should be eliminated since it has no practical medical meaning for emergency care personnel and might well preclude the use, ever, of air and water ambulance transport. This wording actually works against the cost-effective regionalization of many aspects of tertiary care and cost-containment in general.

Under the section listing services that are excluded from the benefit package, cosmetic surgery is only covered if it is needed as a result of an "accidental injury." In the trauma community we never refer to any injury as "accidental" because it connotes that injury is unavoidable and akin to an "Act of God." We use the public health terms "unintentional" injury and "intentional" injury to emphasize that injury is related to personal behavior and therefore preventable. With today's unfortunate upsurge in violence, it would seem important not to exclude from coverage cosmetic surgery needed as a result of either unintentional, or intentional injury.

Academic Health Centers

Because of the strong overlap between academic health centers and Level I trauma centers, the Coalition strongly supports retention of the provisions ensuring access to

academic health centers by requiring health plans to contract with them for the specialized services they provide.

Preemption of Certain State Laws Relating to Health Plans

The Coalition strongly supports retention under the section describing preemption of restrictive state laws of the exemption for emergency medical services. This permits the maintenance and fostering of trauma system development by permitting the state to retain the authority to designate trauma centers and organize pre-hospital emergency medical services accordingly.

Tax Treatment of Organizations Providing Health Care Services and Related Organizations (Title VII, Subtitle F)

The Coalition appreciates that included among the tax incentives provided to HMOs is payment for emergency care provided to an HMO member outside the member's area of residence. This provision supports the operation of trauma systems by helping to ensure that a trauma center treating a seriously injured HMO member, appropriately triaged to the center which is outside the patient's area of residence, receives payment for services.

Workers Compensation and Automobile Insurance (Title X)

The *Act* requires health plans to enter into contracts, or arrange as necessary, for the provision of workers compensation services, and automobile insurance medical services to enrollees in return for payment from the insurance carrier. The *Act* states that health plans can accomplish this through a participating provider, any other contractee, or through a specialized workers compensation provider in the case of injured workers. When defining specialized workers compensation services and automobile insurance medical services, the *Act* never mentions qualified trauma centers despite the fact that they clearly provide services that uniquely address the needs of seriously injured enrollees. The Coalition would like to see language added to Title X which includes trauma care services in qualified trauma centers in the definition of workers compensation and automobile insurance medical services.

CONCLUDING COMMENTS

Regionalized trauma care is cost-effective. Regionalized trauma systems have reduced preventable deaths, disability and have increased the chances of a seriously injured person returning to productive life. By adopting the process of trauma system development that I have described, a rational number of trauma centers are strategically located within a

region. This is determined by need with input from the public, government planners, and health policy experts. Trauma systems could serve as a model for the delivery of other tertiary care.

The Coalition believes that individuals with life-threatening injuries must not be denied access to qualified trauma care. This must be recognized in health care reform policy. Just as excluding Americans with pre-existing health conditions from health insurance coverage is now recognized as counter to sound public policy, so too failure to ensure access for critically injured patients to qualified trauma care would violate accepted clinical standards of medical care. Such an omission could well erode the confidence of many Americans in the clinical standards of care they may receive when calling 911 in an emergency in a reformed health care system. Such an omission would also likely result in much more completely unnecessary disability costing state and federal treasuries hundreds of thousands of dollars in life-long support payments.

I applaud the leadership this subcommittee has provided in recognizing the cost-effectiveness and clinical appropriateness of qualified trauma care in the *Trauma Care Systems Planning and Development Act of 1990* which provides an important foundation for regionalized systems of care in a reformed health care system. The Coalition for American Trauma Care supports your bi-partisan recognition of qualified trauma care and we look forward to working with you in recognizing these principles in health care reform legislation.

(Please see attached the following: 1) Founding Board of Trustees, Coalition for American Trauma Care, and Founding Advisory Council member organizations; 2) the Coalition's document on trauma care and health care reform: "Trauma Care and Health Care Reform: Essential Principles to Ensure Cost-Effective Outcomes.")

**TRAUMA CARE AND HEALTH CARE REFORM:
ESSENTIAL PRINCIPLES TO ENSURE COST-EFFECTIVE OUTCOMES**

- 1) *Cost efficiencies for the entire health care system under a privately regulated model of health system reform utilizing managed competition may be possible. (1)*
- 2) *Regulatory strategies of the 1970s and competitive strategies of the 1980s have often resulted in massive duplication of health care services and technologies, thereby driving up total health care costs while having a poorly understood effect on patient outcomes. (2)*
- 3) *Organized regional systems of trauma care, by providing early definitive interventions for the seriously injured, deliver cost-effective health care services to one of the nation's leading, and the nation's most costly, health care problems. (3,4)*
- 4) *Clinical leadership in trauma system development has led the nation in the commitment to the development of primary and secondary injury prevention strategies, utilization of patient outcome data to improve service delivery to injured individuals, and implementation of practice guidelines to improve and maintain clinical skills. (5,6)*
- 5) *Specific studies show organized regional systems of trauma care significantly reduce duplication of costly trauma care services for seriously injured individuals while also dramatically improving patient outcomes, thereby resulting in considerable direct and indirect health care and social welfare cost efficiencies. (16-33)*
- 6) *The cost efficiencies achieved by organized regional systems of trauma care can be readily compared to quality assurance programs in manufacturing. It costs less to build a product, particularly a complex product like an automobile, right the first time thereby avoiding the need for expensive recalls. (7)*
- 7) *Health system reform proposals should recognize the cost efficiencies inherent in organized regional systems of trauma care for a major public health problem, and should support universal implementation of trauma systems as specified in P.L. 101-590, the Trauma Care Systems Planning and Development Act.*
- 8) *Health system reform proposals should also recognize that access to organized regional systems of trauma care can only be ensured when reimbursement adequately covers the cost of qualified trauma care services, regardless of the source of payment. Since 1985, over 90 trauma centers have closed their doors to seriously injured Americans primarily due to uncompensated care costs. (8,9)*

Basic Injury Facts

- Injury is the leading cause of death and disability for Americans from age 1 through age 44 causing 150,000 deaths and over 300,000 permanent disabilities each year. (10,11)
- Because it most often strikes the young, **injury is the leading cause of years of lost work productivity.** (10)
- Injury is the nation's most costly disease, resulting in an estimated \$180 billion in lifetime costs in 1988 -- more than either heart disease or cancer. (4)
- In young children, injuries cause almost half of all deaths before age 5 and exceed all causes of deaths combined from age 5-14. (10) The most prominent causes of injury death in children are motor vehicle crashes, homicide, fires and falls. (10,11)
- When injury strikes the elderly, those over age 65 are more likely to die, have more complications and longer hospital stays than those under age 65 regardless of the severity of the injury. (12) While the elderly account for 12 percent of the U.S. population, they account for 25 percent of all hospital injury discharges and 25 percent of all hospital injury costs. (13)
- Motor vehicle crashes, which caused 43,500 deaths in 1991 are the leading cause of injury death. (10,11) Firearms are the second overall leading cause of injury death, and the leading cause of death for African-American males age 15-34. (10)
- The leading cause of non-fatal injury and of hospital admissions for trauma care is falls costing the nation only slightly less in lifetime costs than motor vehicle crashes. (10)

What is an organized regional system of trauma care?

- **Medical practice now recognizes that seriously injured individuals should not be taken to the nearest hospital for medical care without regard to the level of care available at that facility.**
- Organized regional systems of trauma care have five components:
 - 1) access**-- 911 availability and public awareness to act quickly to access emergency services;
 - 2) pre-hospital care**--ambulances, fixed-wing and rotor-wing aircraft accompanied by trained personnel who can provide initial resuscitation;
 - 3) triage, transport, and transfer decision-making**--pre-hospital and hospital based emergency care personnel match patient needs with the appropriate level of facility care;
 - 4) acute hospital care**--specialized trauma care facilities with experienced surgeons, other health care personnel and priority access to sophisticated technology and services all available 24 hours per day;
 - 5) rehabilitation**--access to rehabilitation services which are essential to restore injured individuals to productive lives. (5)

- Of the 2.8 million Americans who are hospitalized each year due to injury, approximately 250,000 require the services of a qualified trauma center for medical care because they are at risk of dying or permanent disability. (10,5) While small in number, acute care costs per initial trauma care admission are two to three times greater than the costs of the average acute care admission. The average U.S. acute care admission cost in 1990 was \$4,946 while the average trauma care admission cost in 1990 was approximately \$12,000. (14)

Organized Regional Systems of Trauma Care Save Lives and Prevent Disability.

- Death from injury occurs in a trimodal distribution: one-half of all deaths occur immediately; another 30 percent occur early, between one and three hours post-injury; the rest occur late, days or weeks post injury. (15) Organized regional systems of trauma care provide quick access to definitive care to save those at risk of early death, usually from neurological injury or various kinds of bleeding and probably significantly reduce the incidence of late deaths due to sepsis or multiple organ failure. (15)
- Studies have repeatedly shown that, when organized regional systems of trauma care are implemented, there are dramatic reductions in preventable deaths due to injury (16-20): 56% in Orange County (21), 55% in San Diego County (22), 50% in Washington, D.C. (23).
- One longitudinal study of survival outcomes at an urban hospital over a six year period found significant improvements for severely injured patients: 13.4 more survivors per 100 patients treated per year in years 5 and 6 compared with years 1 and 2. During this six year period, the hospital constructed a trauma resuscitation facility with on-site operating rooms, and the local government implemented an organized regional system of trauma care. (24)
- A recent study of 1,332 femur (thigh bone) fracture patients found that those treated in trauma centers received surgical treatment more quickly, had significantly fewer complications resulting in shorter hospital stays, and had fewer deaths than those treated in non-trauma center hospitals. (25)
- Studies also show the vast majority of even the most severely injured children and adults return to full function and productivity when treated in qualified trauma centers served by organized regional systems of trauma care. (26-29)
- One early study of severely head injured patients treated in a Level I trauma center demonstrates that aggressive, early intervention (usually within four hours) for severely head injured patients significantly increases the number of patients achieving good or moderately good (able to live independently) recovery (60 percent versus 39/40/42 percent) and significantly decreases the number of deaths (30 percent versus 52/49 percent) while the number of poor outcomes remains stable (10 percent versus 6/10/11 percent). (30)

Organized Regional systems of trauma care save health care costs.

- A recent study of worker's compensation claims for nonfatal disabling injuries and of the cost-effectiveness of organized regional systems of trauma care found 10-12 percent lower costs per hospitalized episode and a 10 percent decreased probability of hospitalization for cases treated in states with organized regional systems of trauma care. Extending trauma systems nationwide could lower annual health care costs by as much as \$4 billion and perhaps by as much as \$13.5 billion if preventable death and productivity loss were accounted for. (31)
- Saving young American lives and restoring them to full productivity through the provision of definitive trauma care and rehabilitative services increases the nation's wealth. Studies indicate that providing definitive trauma and rehabilitative care for one year to the typical 20 year old male trauma patient injured in a motorvehicle crash costs about \$45,000 (1988 dollars). (32) One estimate indicates that, at an average annual salary of \$20,000 and assuming a six percent discount rate, this individual would pay back in seven years in local, state and federal taxes the amount it cost to provide injury related health care. Across a lifetime, this individual earning the same modest salary would pay back in taxes alone 12 times more than the initial \$45,000 investment in his life. (32)
- Case law examples, such as the one described below, show that further savings can be achieved through reduced legal and malpractice costs when optimal care in a qualified Level I trauma center is provided:

A 17 year old boy was helping his father trim tree branches when a large limb fell from a significant height and hit him directly on the head immediately rendering him unconscious. Emergency personnel were summoned from a nearby community hospital by family members who requested that the boy be immediately transported to a Level I trauma center several miles away. Instead, the boy was transported to the nearby community hospital that had promoted its trauma service. Inadequate assessment of the boy's severe injury at the community hospital, and delays in transferring him to the Level I trauma center, where he was correctly evaluated and received definitive care, resulted in permanent cognitive, speech and physical mobility impairments. The family sued the community hospital. The out of court settlement amounted to \$2 million. (33)

- Each year, conservative estimates indicate more than 400,000 Americans sustain head injuries and approximately 27,000 survive with moderate to severe impairment. (34) If organized regional systems of trauma care were universally available, many of these individuals could be restored to full productivity with enormous accompanying savings in direct and indirect health and social welfare costs. Reductions in potential malpractice claims alone could finance the implementation of systems. If 30 malpractice claims at an average pay out of \$2 million were prevented because of the availability of definitive trauma care services, \$60 million could be saved – the amount Congress has authorized for implementation of P.L. 101-590, the *Trauma Care Systems Planning and Development Act*.

Despite evidence of their cost-effectiveness, many areas of the United States do not have fully implemented organized regional systems of trauma care, causing unnecessary death and disability particularly in rural areas.

- A 1991 study of trauma system development found that 19 states had no process for trauma center designation, 23 states had a process in place, and 9 were actively developing a process. (9) Many states do have fully implemented organized regional systems of trauma care serving major metropolitan areas, but lack a statewide system. This means many injured Americans are not getting the care they need.
- Lack of a statewide trauma system especially impacts rural areas where the death rate from unintentional injury is twice the rate for the largest cities. (10) Two of every three deaths involving motor vehicles occur in rural areas. (11)
- A retrospective analysis of nearly 40 studies indicates that each year 20-25,000 lives are lost needlessly because organized regional systems of trauma care are not universally available across the United States. (32)
- Hawaii is one of the states that does not have an organized regional system of trauma care and has no process for trauma center designation currently in place. Hawaii is often looked to as the positive model for "managed competition." However, a comprehensive analysis of its emergency medical services system in May of 1991 by the U.S. Department of Transportation's Division of Emergency Medical Services found no system for responding to major trauma. (35) The state has since applied for a federal grant under P.L. 101-590 to begin the process of developing a organized regional system of trauma care. (36).
- Hawaii's basic benefit package under its State Health Insurance Program (SHIP) also does not make appropriate allowance for severely injured patients. Under SHIP, indigent beneficiaries are covered for 5 hospital days. (37) The average length of stay for all trauma patients treated in a Level I trauma center is approximately 10 days. (14) Severely head injured or spinal cord injured patients frequently require much longer hospital stays.

Managed Care and Organized regional systems of trauma care.

- Managed care clearly benefits from the cost efficiencies inherent in organized regional systems of trauma care. Promoting universal implementation of organized regional systems of trauma care and supporting universal access through appropriate payment policies can only add to cost efficiencies for managed care plans.
- Alternatively, attempts to undermine implementation and access to qualified trauma care services by providing care in facilities that do not meet national standards not only deprive injured individuals of appropriate care, but add to health and social welfare costs. Efforts to achieve short-term cost-savings at the expense of greater longer term health and social welfare cost savings must be strongly discouraged.

Organized regional systems of trauma care are an essential component of modern day health care. Any health system reform proposal that fails to ensure access to definitive trauma care and early rehabilitation services for seriously injured Americans will both fail to benefit those who are injured and will fail to realize potential cost savings.

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STATEMENT OF THOMAS M. ROZEK

Mr. WAXMAN. Mr. Rozek.

Mr. ROZEK. Thank you, Mr. Chairman. I am Tom Rozek. I am the President of the Children's Hospital of Michigan, a member of the Detroit Medical Center and Integrated Health System in Detroit, Mich.

Thank you for the opportunity to testify for NACHRI, the National Association of Children's Hospitals and Related Institutions. Children's hospitals care for the sickest children, the poorest children, and children with the most specialized needs.

They train the next generation of pediatric caregivers and they explore the frontiers of pediatric research. Consider our hospital. More than a quarter of our beds are devoted to specialty care and more than half of our care goes to children of low income families. We provide much more than inpatient and emergency care. We also provide care in 120,000 outpatient visits, including 20 some thousand primary care visits each year, and our hospital is a pediatric academic health center for the Wayne State University School of Medicine.

We strive to fulfill our mission of caring for children in an everchanging environment. For example, in response to a very competitive health care market, Children's Hospital of Michigan, as a member of the Detroit Medical Center Health System and the Henry Ford Health System have agreed to coordinate our delivery of primary and subspecialty care for children.

Although the Detroit Medical Center and Henry Ford Health Systems are proud competitors, their trustees believe the principle of collaboration is in the best interest of children. We are beginning to translate this principle into action.

I believe that reform should encourage this kind of collaboration we are trying to achieve in Detroit and throughout Michigan for our children. In speaking to reform, NACHRI makes this point, despite what others may say, there is really a health care crisis for children. They are hurt first by the continuing loss of private coverage and they depend the most on Medicaid, an increasingly unstable program.

Children need comprehensive reform and they need it tailored to fit their unique needs. One of the ways reform should be tailored is to recognize that children's hospitals are an essential part of the health care system safety net for children.

Proposals such as the President's recognize that reform based on competition needs to give special consideration to providers that are essential to the medically underserved. These bills specifically recognize that federally funded clinics are essential because they are prepared to meet the primary care needs of people in medically underserved areas and they are able to do so because they are publicly financed. They exist because the private marketplace does not meet the needs of the medically underserved.

Children's hospitals and public hospitals are also essential to the medically underserved. For example, children's hospitals on average devote more than 44 percent of their care to children who depend on Medicaid. This does not include the care they give to children whose families are uninsured or unable to pay.

More than and more it is not unusual for a children's hospital to devote over half of its care to children of low income families. For these children, a children's hospital, through those professionals dedicated to pediatrics, is both a primary and specialty care provider. It serves children in its outpatient clinics, emergency rooms and patient unit.

Our hospital is an example of a children's hospital that is an essential provider of both outpatient and inpatient care to low income children. More than 50 percent of our inpatient care goes to children who depend on Medicaid. In many of our outpatient clinics, including our primary care clinics, more than 70 percent goes to children assisted by Medicaid.

Detroit does not have a public hospital, but in terms of mission and service, Children's Hospital of Michigan functions as if it were the public hospital for children needing primary and sub-specialty care. Because of this, NACHRI believes that children's hospitals and public hospitals are essential to medically underserved populations and should be designated as essential providers.

We recommend that reform explicitly designate as essential providers the inpatient and outpatient services of those children's hospitals serving a disproportionate share of low income patients.

NACHRI also recommends for at least a transition period a health care plan should be subject to three requirements. First, the plan should contract with essential providers to ensure the inclusion of providers upon whom medically underserved people rely. Second, plans should not deny coverage for the use of services of essential providers without prior approval of the health care gate keeper.

Third, the plan should negotiate with essential provider payments that meet minimum standards. Viewed from a pediatric perspective, it is especially appropriate to designate children's hospitals as essential providers. Children are the largest segment of the Nation's poor and their proportion is growing.

Mr. Chairman, this concludes my oral remarks. We have written testimony given. I would be happy to try and answer any of your questions.

Mr. WAXMAN. Thank you very much.

[Testimony resumes on p. 391.]

[The prepared statement and addendum of Mr. Rozek follow:]

STATEMENT OF THOMAS M. ROSEK

Mr. Chairman, I am Thomas M. Rozek, President of the Children's Hospital of Michigan, which is a member of the Detroit Medical Center in Detroit, which is the academic health system of Wayne State University.

I also serve as a trustee of NACHRI -- the National Association of Children's Hospitals and Related Institutions, whose Council on Public Policy I chair. On behalf of NACHRI, which I represent today, I want to thank you very much for the opportunity to testify before your subcommittee, which has played such a critical role in strengthening the Medicaid safety net and the Title V Maternal and Child Health Block Grant for the millions of children of low income families.

NACHRI represents more than 130 institutions in the United States and Canada, including free-standing acute care children's hospitals such as my own, pediatric departments of major medical centers, and specialty children's hospitals devoted to specific services such as rehabilitative care for children.

Children's Hospitals

Children's hospitals are driven by missions that commit them to serving all of the children of their communities, including the sickest, poorest, and those in need of the most specialized care, through the delivery of primary and subspecialty care in both inpatient units and outpatient clinics. Children's hospitals also are driven by missions that commit them to serving the children of tomorrow through medical education, which trains the next generation of pediatric health care professionals, and research, which advances the base of knowledge and the state of the art of pediatric health care.

For example, on average, children's hospitals devote nearly 50 percent of their care to children whose families depend on either Medicaid or charity, and they devote more than 70 percent of their care to children with at least one or more chronic or congenital conditions. Although they represent only seven percent of the nation's hospitals, children's hospitals and the pediatric departments of major university medical centers train the majority of pediatricians and in many instances the vast majority of pediatric subspecialists in the United States.

Children's Hospital of Michigan

Children's Hospital of Michigan is representative of the children's hospital community I have described. It is a private, voluntary, not-for-profit 260 bed tertiary care center recognized as a leader in pediatric health care, education, and research:

- More than a quarter of the beds of the Children's Hospital of Michigan are devoted to specialty care, and more than half of our care is devoted to children of low income families, most of whom depend on Medicaid.
- In addition to more than 13,000 admissions and nearly 70,000 emergency room outpatient visits annually, Children's Hospital of Michigan provides care through more than 125,000 outpatient clinic visits, including more than 20,000 primary care clinic visits.
- Children's Hospital of Michigan also serves as the pediatric academic health center for the Wayne State University School of Medicine.

Children's Hospital of Michigan continually seeks to fulfill its mission of service to the children of its community in response to an ever-changing environment. For example, in response to the severe shortage of private practice physicians caring for children in our inner-city, Children's Hospital of Michigan plans to sponsor the establishment of small group pediatric practices in downtown Detroit to make these services more readily available.

In response to an increasingly competitive health care market, Children's Hospital of Michigan, as a member of the Detroit Medical Center, and the Henry Ford Health System have entered into an agreement to improve access to primary and subspecialty care for children in Southeastern Michigan by forming the Child Health Network to coordinate care. Although the Detroit Medical Center and the Henry Ford Health System are each proud competitors, their trustees have agreed that the principle of collaboration is in the best interest of meeting the needs of children, so many of whom have low family incomes and so few of whom require highly specialized services. We are beginning to work together to translate this principle into coordinated delivery of care. I believe that health care reform based on managed competition should provide incentives that foster the kind of coordination for the sake of children which we are attempting to achieve in Detroit.

Children's Hospitals as "Essential Providers"

In speaking about health care reform, NACHRI and its member hospitals have sought to make two basic points:

- First, children's hospitals believe children especially need comprehensive health care reform, because children often are the first to be hurt by the continued erosion in private health care coverage and rapid changes in the health care marketplace.

That is why we at Children's Hospital of Michigan take pride in the life-long commitment of Congressman John Dingell to

achieving national health care reform. It is why children's hospitals throughout the United States have applauded the leadership of President Clinton and Hillary Rodham Clinton, as well as so many Members of Congress including yourself, in making health security by guaranteeing coverage of comprehensive benefits for all Americans our top national domestic priority.

- The second point children's hospitals make on health care reform is this: we believe that reform must be tailored to fit children's different health care needs, because when it comes to children's health care, one size won't fit all.

I will elaborate on these two points in my written statement, but for the purpose of this panel discussion, I would like to focus my oral remarks on the importance of recognizing children's hospitals as designated "essential providers" in health care reform based on managed competition.

Proposals such as the President's "Health Security Act" and the Senate Republican leaders' "Health Equity and Access Reform Today Act" have recognized that reform based on competitive commercial health care markets needs to give special consideration, at least during the early years of reform, to providers of primary care that function as "essential providers to low income people." These providers -- federally funded community health clinics and others -- are essential, because they are prepared to meet the primary health care needs of people living in medically underserved areas, and they are able to do so only because they depend substantially upon public financing. They are guided by their missions of serving this challenging population, precisely because the commercial marketplace, by and large, does not meet the needs of the medically underserved.

In many communities, children's hospitals as well as public hospitals clearly are also essential to the ability of the medically underserved to obtain care. For example, nationwide children's hospitals on average devote more than 44 percent of their care to children who depend on Medicaid. This does not include the care they provide to children of families who are uninsured and unable to pay for their care. Increasingly, it is not unusual for a children's hospital to devote 50 percent, 60 percent, or more of its care to children of low income families. In contrast, on average, community hospitals devote less than 20 percent of their care to people who depend on Medicaid, including both children and adults.

For children of low income families, the children's hospital often is both primary and specialty care provider -- the hospital serves the child through its outpatient clinics, its emergency room, and its inpatient services. As the proportion of all pediatricians serving children under Medicaid has declined, and the proportion of the individual pediatrician's practice devoted to

Medicaid recipients on average has declined, children's hospitals' delivery of care to children who depend upon Medicaid has increased steadily.

Children's Hospital of Michigan is an example of a children's hospital that functions as an essential provider of both outpatient and inpatient care to the low income children of our community. More than 50 percent of our inpatient care is devoted to children who depend on Medicaid and Medicaid managed care, and in many of our outpatient clinics, including our primary care clinics, more than 70 percent of our care is devoted to children who depend on Medicaid. Detroit does not have a public hospital, but in terms of mission and service, Children's Hospital of Michigan functions as if it were the public hospital for the children of our city seeking either primary care or subspecialty care.

NACHRI recommends that children's hospitals and public hospitals that are essential to medically underserved populations be designated in the law as "essential providers." With respect to children's hospitals, NACHRI recommends that health care reform legislation explicitly designate as essential providers for both inpatient and outpatient services those children's hospitals serving a disproportionate share of children of low income families, as defined by Section 1923(b)(1)(A) in Title XIX of the Social Security Act. This definition would limit essential provider designation to those children's hospitals whose Medicaid inpatient utilization rate is one standard deviation above the statewide mean.

NACHRI further recommends that during at least the first five years of reform's implementation, accountable health plans should be subject to three requirements:

- First, plans should be required to contract with designated essential providers in order to ensure the inclusion of those providers who now serve low income individuals and their families.
- Second, plans should not deny coverage for those families that use the services of contracted essential providers without the prior authorization of their assigned primary care coordinator or gatekeeper.
- Third, plans should be required to negotiate with essential providers a rate of reimbursement that meets minimum standards.

In addition, Federal policy on essential providers should continue beyond the initial transition period of reform until such time as health plans demonstrate their ability to assure physical as well as financial access to care for those living in medically underserved areas.

Viewed from a pediatric health care perspective, it is especially appropriate to recognize children's hospitals as essential providers. Essential provider policy is an attempt, as health care reform is implemented, to maintain a safety net for the poorest populations. Children are the largest segment of the nation's population living in poverty, and their proportion is growing. As a consequence of both their poverty and the improvements in Medicaid assistance which Congress has enacted in recent years, Medicaid is children's health care safety net today. Half of all Medicaid recipients are children, and nearly one in three children depends on Medicaid. Essential provider designation of children's hospitals, along with publicly funded primary care clinics and public hospitals, is needed to maintain a children's health care safety net tomorrow.

It is important to note, too, that the concept of "essential provider" as developed in these bills is narrowly defined in terms of only those services essential to low income populations. I believe an equally compelling case can be made for managing the competitive market to ensure access to "essential providers" in terms of highly specialized and regionalized services, such as regional pediatric trauma centers, upon which children of all income levels are dependent. When thought of in these terms, the children's hospital also would be considered an essential provider for children throughout many states and regions.

Mr. Chairman, that concludes my oral remarks. In the balance of my written testimony I expand upon NACHRI's views on health care reform and its implications for children.

Children Need Comprehensive Health Care Reform

Children in particular need comprehensive health care reform, because they are often the first to be hurt in the continued erosion in commercial health care coverage. Studies show that in the struggle to cope with rising health insurance costs, both employers and individuals often draw the line first at paying for dependent coverage. Loss of dependent coverage, as well as pre-existing condition exclusions and life-time maximums on coverage, hit children hard, especially those requiring the care of a children's hospital.

As a consequence, more than one in three children in the United States now depends either on Medicaid, which is a critical but often underfinanced poverty program, or on charity to pay for their health care. That proportion continues to grow. In 1992, 13.5 million children depended upon Medicaid and another 9.5 million children were uninsured, representing 35 percent of the nation's 65.1 million children, according to estimates based on U.S. Census Bureau data.

Medicaid has become the nation's safety net for children's access to health care -- particularly children with special care needs. The emergence of Medicaid as children's health care safety net has been a tremendously important development. The children's hospitals and the families they serve are deeply grateful to the members of this subcommittee who supported efforts for so many years to enable Medicaid to cover more and more children left without private insurance. But we know that Medicaid often has been challenged to fulfill its promise to children because of inadequate resources for eligibility, outreach, and payment. We also know that many states are now stretched to the financial limit by their Medicaid programs. In today's fiscal and political climate, Medicaid and charity are an imperfect and ultimately financially unsustainable safety net for children.

Children also are at the frontlines of change in the health care delivery market place, and the pace of that change is about to step up substantially because of Medicaid. In health care marketplaces around the country, we are seeing a significant surge in the conversion of traditional indemnity coverage for fee-for-service health care into managed care coverage, including enrollment in risk-bearing, capitated health plans.

Many state Medicaid programs are contemplating what the State of Tennessee has received federal permission to do -- enroll all Medicaid recipients into capitated managed care plans in a matter of only months. Since half of all Medicaid recipients are children, and 70 percent are mothers or children, the conversion of Medicaid fee-for-service to capitated managed care will be especially significant for children and their ability to receive the care they need. If implemented carefully, managed care holds great potential for children by creating incentives for them to receive health services when they can benefit most from them. But make no mistake about it, the statewide Medicaid managed care experiments upon which states are embarking are experiments that affect primarily children.

That is why we believe comprehensive health care reform, based on mandated employer-financed health coverage, is so important for children, both to give all children coverage of uniform health care benefits and to influence the way in which health care is financed so that coverage translates into access to appropriate care.

Health Care Reform Should Be Tailored to Fit Children's Needs

Many Members of Congress have visited a children's hospital -- as a parent, family member, or friend of a patient or as a guest of the hospital. You know that our institutions look and feel very different from other hospitals. You know that the care givers who work with our institutions often have different training and different experience than care givers in other hospitals have.

All of these differences that define the character of a children's hospital might be summed up by the slogan: "When it comes to children, one size won't fit all. We must tailor health care to fit their needs." This slogan may have a simplistic ring to it, but it has profound implications for the way we deliver care to children. Just last summer, the Institute of Medicine highlighted this point by issuing a major report on emergency care for children. It concluded our health care delivery system fails to meet the needs of children who suffer from injury or trauma, because all too often our emergency and trauma care services are designed to fit the needs of adults or "average" people, not the needs of children.

For example, because children have smaller veins that often are not receptive to emergency injection of fluids, such injections may need to be made directly into their bone marrow. And because children's blood supply is smaller, injured children frequently experience a much faster drop in blood pressure. As a consequence of emergency services not being designed to fit these kinds of different needs, children's survival and recovery from injury or trauma suffer.

The children's hospitals believe it is equally true that when it comes to health care reform, one size won't fit all. We must tailor the requirements of reform to fit children's needs. I would like to give you examples of what I mean by focusing on four areas of consensus on health care reform between leaders in both political parties. These areas of consensus involve commitments to uniform benefits, managed care, cost containment, and Medicaid's reorganization.

Uniform Benefits Leaders in both political parties have advocated that the federal government establish, by act of Congress or independent commission, a uniform benefit package for all Americans, with special emphasis on primary and preventive care. That is a very important, bipartisan commitment, which is sure to benefit children, for whom preventive and primary care often are the least expensive and promise the best financial returns in terms of well-being and future productivity. However, as experts in the care of children with special care needs, children's hospitals know that it is equally important to focus attention on how the benefits will cover the needs of the child with a chronic or congenital condition, such as cerebral palsy.

For example, if they limit coverage for rehabilitation to treatment of a condition resulting from an "illness" or "injury" or related to an "acute care episode," uniform benefits could be subject to the risk of interpretation that they do not cover congenital conditions, which are not the result of illness, injury, or acute care episode. Similarly, a limit on coverage to treatment that results in "improvement" of function could deny coverage of therapies that would enable children with special needs to "maintain" a level of function, allowing them to attend school or

live at home. Or it could deny coverage of therapies prior to surgery that could be essential to a successful outcome. In addition, an "improvement" standard may not recognize the need for "habilitation" to help children attain function for the first time.

That is why children's hospitals say that the uniform benefits in health reform must be tailored to fit all children, including children with special care needs who require access to ongoing specialized care, which is not the same as long term care.

Managed Care Leaders in both political parties believe that in order to restructure the way in which we deliver care, we need to promote more enrollment of individuals and families into risk-bearing, capitated health plans. Whether they call it managed competition, managed collaboration, or something else, both Democratic and Republican leaders on health care reform believe we should give health plans an incentive to manage the care needs of individuals cost-effectively by giving them a single, fixed per capita payment -- adjusted for the risk associated with the individual's health needs -- for every individual enrolled.

Managed care has great promise to meet the needs of children if financial incentives facilitate their access to primary and preventive care. Indeed, through the provision of multi-disciplinary care involving the family, many children's hospitals have pioneered in managed care in the best sense of the word by trying to make sure the child receives the most appropriate care, including inpatient care, only when it is truly necessary.

But if managed care is purely cost-driven, it can have the opposite effect for children, denying them access to appropriate care instead of assuring it. The fact is that many of the protections essential to managed care -- risk adjustment, public cost reporting, measures of quality and outcomes -- have not been developed for children, in particular children with special care needs. At the same time, because so few children comparatively require hospitalization, they are more dependent than adults on having access to regionalized centers of care. These are providers, both institutional and individual, who see a large enough volume of pediatric patients with specialized conditions that they are able to achieve and maintain both expertise and efficiency in pediatric care.

Such institutions -- children's hospitals -- also carry the added costs of their commitments to serving a disproportionate share of low income patients, training the future generation of pediatric health care professionals, conducting pediatric medical research, and caring for the sickest of patients. If driven only by costs and lacking adequate tools for risk adjustment or measures of quality for children, managed care plans often will refer only the sickest and most expensive patients to children's hospitals and other pediatric specialized facilities, making them financially unsustainable. Or, to gain competitive advantage, managed care plans will seek to prevent children's hospitals from contracting

with multiple plans, which often is essential for the hospital to serve a large enough population of children to sustain its specialized services. These are not concerns borne out of speculation; they are the real life experiences of children's hospitals seeking to fulfill their missions in competitive markets driven by managed care.

That is why children's hospitals believe it is so important that health care reform built upon capitated health plans must manage the competitive market to ensure children's access to the care they need. It is important to require that health plans:

- provide access to pediatric specialists and subspecialists, including at least one hospital that specializes in the care of children, so that when a child needs a cardiologist or pulmonologist or other subspecialist, it is one who is trained in pediatric cardiology or pediatric pulmonology or other pediatric subspecialties;
- give parents choice among providers for both primary and specialty care, including choice of specialists to deliver primary care to children with special care needs, should they demonstrate the capacity to provide such care;
- allow pediatric providers to contract with multiple plans;
- contract with and refer patients to hospitals that have demonstrated themselves to be "essential" to the children of low income and medically underserved communities;
- contract with and refer patients to recognized centers of excellence and specialization for pediatric trauma care, level III neonatal intensive care, pediatric intensive care, high risk perinatal care, and other, highly specialized services;
- separate the financing of graduate medical education from patient care reimbursement, by requiring all payors of care to contribute to a pool of funds, which are used to meet both the direct and indirect costs of graduate medical education and are paid to the institutions that incur those costs; and
- account to the public for the costs and quality of care, consumer satisfaction, and health status of the population served in terms that are specific to children and their needs.

Cost Containment There has been much disagreement both between Democrats and Republicans, and within their respective parties, about whether and how to cap the growth in health care spending nationwide, the growth in commercial insurance premiums, or the amount of reimbursement given to individual providers.

However, as institutions that devote a major portion of care to children assisted by Medicaid, children's hospitals are struck by the fact that leaders in both political parties strongly agree

on capping the growth in Medicaid, at least at a per capita level. That is the equivalent of a de facto spending cap on health care spending for children. Even if they may not support the principle of government caps on health care spending, children's hospitals already live with the reality of caps on Medicaid. We believe it is imperative to talk about the need for cost containment strategies to be adjusted to fit children's needs.

Let me explain why this is so important. Children have different health care resource requirements than adults have, and the patients of children's hospitals have different resource requirements than children receiving care in general hospitals. For every hour in the hospital, a child on average requires 31 percent more routine nursing care than an adult; a child younger than two requires 45 percent more care than an adult. The patients of children's hospitals require even more intensive care, because they are younger, sicker, and more likely to have a chronic or congenital condition than the pediatric patients of general hospitals. Since nursing care is a major portion of the expense of hospitalization, these differences can have significant implications for the resource requirements of children.

Too often, strategies to cap health care spending fail to take into account these differences. We see proposals to cap national health care spending based on an extrapolation of historical rates of health care expenditures, in which the costs of children's and adults' care have been averaged together. In addition, children have been disadvantaged in historical spending -- because they have been disproportionately poor, dependent upon Medicaid which has inadequately reimbursed care, and dependent upon primary and preventive care, which indemnity plans traditionally did not cover. Caps on health care spending will not make sense for children if they are based on historical spending, instead of an assessment of children's real health care needs.

Most advocates of capitated payment for health care have recognized the importance of risk adjustment -- adjustment of capitation for the risk of higher or lower costs of care associated with an individual. Without such risk adjustment, a health plan or health care provider who cares for a population that is disproportionately sicker would be at financial risk. This is exactly what a children's hospital is -- an institution which specializes in caring for higher risk children with the most complex care needs. However, experts in capitation and risk adjustment have testified before Congress that risk adjustments specific to the needs of children -- particularly children with special care needs -- simply do not exist, and will take years to develop. That is why children's hospitals believe we must begin now to invest in risk adjusters for children, even before embarking on health care reform. And if reform is implemented before pediatric risk adjusters are developed, interim measures, such as mandatory reinsurance for a wide range of children's chronic and congenital conditions or exclusion of these cases from capitation, will be necessary.

Children's hospitals have learned the necessity of adjusting cost containment strategies to children's needs through years of living with state Medicaid programs and private payors, which have adopted the Medicare diagnosis related groups (DRG) payment methodology, even though it was not designed for a pediatric population. According to financial experts whom the federal government often has used for payment policy analysis, no children's hospital could survive financially if it were subject to the Medicare payment system unadjusted for the needs of children in general and the needs of children's hospitals' patients in particular. In fact, these experts have stressed that in health reform based on competition, it is essential that the adjusters be based primarily on children's needs.

That is why children's hospitals believe that in health care reform, cost containment strategies must be tailored to fit children's needs.

Medicaid According to opinion surveys, most people think Medicaid is either a welfare program or Medicare. But to children's hospitals, Medicaid represents the nation's largest and most important child health program. No single program, public or private, affects more children nationwide or more children in children's hospitals. Therefore, it is especially important that great care be given to how health care reform transforms Medicaid.

Let me give you an example. Many leaders in both political parties have called for the elimination of Medicaid disproportionate share payment adjustments -- extra payments given to hospitals that serve a disproportionate share of low income patients. They contend that such disproportionate share payments are only needed to pay for the costs of care of charity patients. With the achievement of universal coverage, they believe, such payments no longer will be necessary.

However, to children's hospitals, disproportionate share payments represent something entirely different. In most states, including Michigan, the Medicaid program makes disproportionate share payment adjustments because the base Medicaid payment rate is substantially inadequate to cover the costs of care. These payment adjustments have been critical to the ability of children's hospitals to play such an important role in providing access to care for children of low income families.

If Medicaid financing continues at historically inadequate levels, exacerbated by the elimination of disproportionate share payments, health plans and communities with larger numbers of low income people will be particularly hard hit, as will the institutions devoted to serving them. This will be doubly true for institutions such as children's hospitals, which serve large numbers of both low income and high risk patients.

Similarly, most people are not aware that contained within Medicaid is an extremely important national health policy for children. It is a commitment, through EPSDT, that every Medicaid eligible child is entitled to medically necessary care, regardless of whether the services required to provide that care are otherwise provided by states to adults under Medicaid. Proposals that eliminate Medicaid need to take into account how to preserve this commitment to medically necessary care to the most vulnerable children in our society, so that they are not worse off as a result of national health care reform.

These are examples of why children's hospitals say that Medicaid's replacement in health care reform needs to be tailored to fit children's needs.

Conclusion

In recent years, many Members of Congress have worked to strengthen Medicaid so that it could become a true safety net for children and to move the Congress toward the achievement of national health care reform. The children's hospitals and the children and families we serve are deeply in their debt.

We also recognize that despite the valiant efforts of many, no one political leader has done more than President Clinton to move comprehensive health care reform to the top of the nation's political agenda. We strongly support his leadership, and we strongly support many of the principles we believe are fundamental to his health care reform initiative: universal coverage, comprehensive benefits, employer-based coverage, assurance of choice among health plans, recognition of the roles of essential providers of care to low income patients and academic health centers treating rare conditions, separating the financing of graduate medical education from patient care reimbursement, sustaining Medicaid eligible children's access to medically necessary care, and more.

A number of other important proposals also attempt to address these basic principles. We believe the President's plan is a good place from which to build a coalition for health care reform, both in terms of his fundamental commitments and in terms of his willingness to consider changes in the details.

As institutions who are bound by their missions to focus always on the needs of children, children's hospitals believe that we need to balance continually our commitment to advocating for comprehensive reform with our commitment to making sure that all children have access to the kinds of services they specifically need. Children's hospitals and the care givers we house have devoted professional and personal lifetimes to the details of children's health care needs. It has become a cliché in health care reform to say that the "devil is in the details," but it is nonetheless an absolute necessity in children's health care -- whether it involves making a diagnosis, prescribing a treatment, or assessing health care reform.

Children's hospitals welcome the opportunity to work with this subcommittee to advance health care reform for all Americans and to make sure it fits the needs of all Americans, including our children. Thank you for the opportunity to present NACHRI's views on health care reform.

Addendum to Testimony

As NACHRI noted in its January 25th testimony to the Subcommittee on Health and the Environment, "Leaders in both political parties believe that in order to restructure the way in which we deliver care, we need to promote more enrollment of individuals and families into risk-bearing, capitated health plans. Whether they call it managed competition, managed collaboration, or something else, both Democratic and Republican leaders on health care reform believe we should give health plans an incentive to manage the care needs of individuals cost-effectively by giving them a single, fixed per capita payment -- adjusted to the risk associated with the individual's health needs -- for every individual enrolled."

NACHRI believes that managed care holds great promise to meet the needs of children, if the financial incentives encourage appropriate coordination of care, including maximizing access to primary and preventive care. However, if it is only cost-driven, managed care can have the opposite effect, denying children access to appropriate care or denying adequate resources to sustain such care.

Potential UR Problems

For example, the conduct of "utilization review" (UR) by plans -- the review and authorization of care and its financing by plans, independent of the care giver -- has significant impact on access to appropriate care. The purpose of UR is to contain costs and act as a patient care safeguard by ensuring quality and effectiveness of care. However, the experience of individual children's hospitals suggests problems that need to be addressed in any national health care reform that would promote managed care:

- UR can be arbitrary and capricious. Providers complain -- and some have taken legal action against -- what they believe is an arbitrary and capricious mechanism by which third-party payers place the savings of dollars ahead of patient care.
- UR can contribute to expensive bureaucratization of health care. Providers and third-party payers may spend considerable resources building or underwriting utilization review bureaucracies as they spar over costs charged or care given. Instead of benefiting patients, these bureaucracies can place patients at risk by redefining standards of care purely on the basis of the insurers' fiscal interest.
- Avenues of appeal can be few or non-existent. UR disallowances may be made in such a manner as to make it economically infeasible for a provider to contest the denial. Moreover, some insurers do not offer an appeal process.

- Third-party reviewers may not be knowledgeable of patient needs. Some third-party payers may use physician reviewers who are lacking in medical knowledge and experience relevant to the patient's illness. This can be especially true in pediatrics where standards for UR are not always appropriate as applied. Some third-party payers may use UR standards that are applicable to adult but not pediatric patients.
- Standards of care are kept secret and changed without notice or discussion. Third-party payers may change standards, disregarding accepted medical standards. In addition, they may not share their guidelines with providers or involve them in their formulation.

Recommendations

The issue is not whether UR should occur. It is both appropriate and essential to effective managed care that is carried out in the best interests of the patient. The issue is the definition of the processes by which UR is conducted to discourage abuse and encourage appropriate patient care. One approach would be to require that states, as a part of health care reform, to establish guidelines for reasonable UR. But whether it is by federal or state direction, policy defining UR should do the following:

- Require a process by which UR agents or agencies and their procedures must be approved by a formal certification process overseen by the state;
- Require disclosure of all complaints and grievances filed against the review agency or agent requiring corrective action;
- Establish professional standards, including:
 - UR agencies and agents should be licensed in the same profession and have the same specialty or subspecialty, which they are reviewing.
 - UR determinations that may result in denial or care or precertification should include the evaluation, findings, and concurrence of a professional trained, licensed, and experienced in the relevant specialty or subspecialty.
 - UR agencies and agents should give both health care providers and patients language that is written clearly and designed to be easily disseminated.
 - UR determinations of inappropriate care should not be made until after the review agent has discussed the determination with the patient's attending physician.

- UR determinations should be given to the care provider in writing, including the evaluation and findings of the agent.
- Health care providers should not be prohibited from discussing the UR process and determination with the patient.
- UR agents should be reasonably accessible to providers during normal business hours and payment should not be denied for care given during a period when the review agent is unavailable for consultation.
- UR procedures should comply with accepted standards for patient confidentiality, including applicable law.
- UR should not employ contingent fees or other financially based performance incentives which link the review agent's compensation to denial of authorization of treatment and its payment.
- In appeals of UR rejection of reimbursement, whichever party loses the appeal should be responsible for paying for the cost of the appeal, plus the amount in the dispute to the winning side.
- UR should be conducted on outlier cases or those cases that fall outside of a pre-determined standard of normalcy developed through the promulgation of practice standards.

Adoption of these kinds of policies will encourage responsible UR to be focused on ensuring appropriate patient care, not arbitrary reimbursement denial. They are essential to the fulfillment of the objective of health care reform -- universal coverage that ensures access to affordable care under a comprehensive benefit package.

Mr. WAXMAN. The five of you have given us I think very important testimony. You do represent the essential community providers and according to Dr. Lee this morning in his testimony, he thought that the provisions in the legislation which set out the designation of an essential community provider would allow you to thrive under the new managed competition system that the administration proposes.

Do you agree with him or do you disagree with him? Mr. Gage.

Mr. GAGE. Well, I will leap in. First, I should point out that at NAPH we have worked very, very closely with all of the organizations who are represented up here today, going back for many years, but certainly for the last year, both with the administration and with this committee, and many of the things we certainly subscribe to and agree with absolutely everything that was said by the other members of this panel, and I think we share some of the concerns.

We are sort of being killed with kindness by this bill in a sense. There are many, many provisions in this bill that are very, very important and admirable and as they are written provide some assistance to fill in some of the gaps that are still going to be left with the enactment of particularly a managed competition-based system, but I think as you have expressed and several other members of the committee, they are all underfunded.

They are not clearly integrated with one another, as I think they should and must be. Just to give an example, some reference to the so-called vulnerable population payment that is intended to go to hospitals that is fixed at approximately \$800 million, which is about 1/20th of the size of a current Medicaid disproportionate share adjustment that it is intended to replace and also is intended to pay for services to undocumented immigrants among others.

Very, very serious concern about how those payments are going to be targeted. There is a lot of ambiguity about who will be eligible for them and certainly they are not set at an adequate level to meet that need. There are similar concerns about risk adjustment, about taking patient care in underserved areas into account in allocating residencies, and in some of the enabling services, which is left open-ended in the fact that some of these programs are administered at the State level and some at the Federal level, and so we do have concerns.

I just want to conclude, I don't want to monopolize the answer here, by saying, however, that they have been addressed we think in good faith and we certainly hope that Dr. Lee and others we have spoken with can be taken at their word in terms of negotiating more adequate provisions. We do support this legislation.

Mr. TRUNKEY. The answer to your question is, we have major concerns because even under current Medicare and Medicaid reimbursement, 100 trauma centers have closed. Most of these in the inner city areas. Some closed because of higher standards, which is appropriate, but the ones closed in inner city areas because of reimbursement. Because as Medicare reimbursements and Medicaid reimbursement decreases before universal coverage, the trauma centers are the ones that are going to be most vulnerable.

Mr. WAXMAN. You are worried about the transition. Certainly when everybody is covered, that ought to be a tremendous boost to trauma care.

Mr. TRUNKEY. Correct, but it is the transition because right now we have trauma centers closing. The other issue of concern quite frankly is the undocumented alien. We provide that trauma care to those people and not to include them seems to me inappropriate.

Mr. ROZEK. Mr. Chairman, two points. One, in an environment that is trying to drive costs out of the health care system and invest in this—this Nation in other areas to improve our productivity, the children's hospital, again, the way the legislation is currently written, could be adversely impacted from this perspective: A child—we care for children with ENT problems, for minor surgery, for outpatient primary care services as well as we provide services for patients with inguinal hernias and a number of other major deficits, and in the current managed care environment, what happens is that the managed care provider tries to find the lowest cost provider and if in fact we have to take care of only the patients with enormous medical and surgical needs, that will put us in a competitively poor position, and I think that is—you know, that would cause us to have some very significant difficulty.

Mr. WAXMAN. Doesn't the bill provide that all plans in an area would have to contract with essential community providers so that the contract would be for a family to take their children to a children's hospital for any service, not just for certain services? Do you feel that they are going to designate only the more specialized children's services to be paid for when it is at a children's hospital?

Mr. ROZEK. The way I read the plan, it is not specific enough to do that, and I think we need to really level the playing field for us to be able to care for those patients. We, in fact, provide secondary services and primary care services to diabetic children throughout the State of Michigan through a private partnership with the Michigan Masons, and we in fact provide our clinics out in those communities, and that gives us an opportunity to provide a continuum of services to kids, and if we are going to be selectively put out based upon just cost, and we do have a higher level of cost because of the education costs that we provide in caring for—and developing residents—I should say educating residents and putting them out in practice throughout the State of Michigan and other States, that is—that could be a major negative for us in vying to be in a competitive market.

Mr. WAXMAN. Ms. Trice.

Ms. TRICE. Mr. Chairman, we do support essential providers, but from the community health center point of view, I guess the concern that we have here, again, it is that we would not end up, as we currently do, with all of the sicker patients, because I think it needs to be understood that those of us in the rural and the inner city area deal with that population that bring really more complicated health problems, and I know in Miami and other areas, we too have a severe problem with undocumented persons, so it is the funding that would go along with ensuring that the dollars are there to care for those people that we are concerned about.

Mr. WAXMAN. Mr. Gallegos.

Mr. GALLEGOS. Mr. Chairman, I would just like to echo the comments of my colleagues here that we just need to be concerned that essential community providers, that we recognize the fact that there are the associated costs with providing services to vulnerable populations, whether that be migrants or seasonal farm workers, people with HIV, substance abuse, low income or uninsured, that there be some type of safe gap provision that allows—the essential community provider cannot be placed at undue risk.

This particular program of community health centers have been underfunded for a number of years. My providers, for example, earn 60 percent of what their counterparts will earn out in the private sector.

My facilities need constant repair, they need to be modernized. So we are dealing with an infrastructure that is underfunded, that we really need to invest more in that system, and we have the experience in working with these particular populations. I think we have the expertise and we have proven to be cost effective.

Mr. WAXMAN. From your point of view, you want to make sure that this law provides that all plans have to contract with you, pay you adequately, not discriminate in any way so that you would be able to handle a patient population that has relied on each of you for its care, but from the other side of things, the plans themselves, I might argue, well, we don't want to have to contract with these providers because they are more expensive.

It doesn't enable us to control the costs the way we need to in order to be competitive. For example, at our December 9th hearing, a representative from Kaiser Permanente, which is the Nation's largest private health care program, testified against the requirements in the President's plan related to contracting with essential community providers because it would make them an indemnity insurer. They would have no ability to oversee the quality or control the costs, and it was suggested that we amend the legislation to provide incentives to contract, but not require it.

How can we integrate essential community providers like yourselves into closed panel HMO's like Kaiser?

Mr. TRUNKEY. We have already done that in Portland, Oreg., with trauma care. We showed the Kaiser system through quality assurance mechanisms that our costs were cheaper than they could do it for themselves.

Furthermore, we showed that the outcome was better when we did it compared to places where you don't have a trauma center. For trauma care, I think that the evidence is absolutely overwhelming that you can prevent unnecessary deaths, prevent unnecessary disability, and those cost savings are translatable to whichever organization you contract with.

Mr. WAXMAN. I can see that for a trauma center, but the other four give primary care as well as specialty care. How would you respond to this concern by Kaiser?

Mr. ROZEK. In my testimony, I talked about the integration of our two health systems from a pediatric perspective, that is the Detroit Medical Center and the Henry Ford Health System, and clearly that the Henry Ford Health System had to decide whether or not it was going to purchase or build services, and in an organization like ours that we have already \$100 million worth of assets focused

in on the delivery of family center care for the child, what is the value of replicating that kind of service in the community of Michigan and the community of Detroit?

We are recommending that essential providers be guaranteed the opportunity to negotiate payment rates with plans and that the negotiations should occur within minimum standards. We also think that such minimum standards should be adjusted to reflect differences in children's health care needs.

If we go through that process, that is a reasonable negotiation process and that is—we spent about a year-and-a-half working with the Henry Ford Health System in negotiating a reasonable rate. We also have contracts with HMO's and PPO's throughout the State, and we in fact negotiate with them reasonable rates and the 1,000 patients that are transferred to our hospital for NICU care, about 75 percent of them are transferred back to the primary care provider in the community.

So we don't want the child in our hospital for any extended period of time. We want the child to be—receive quality services cost effectively, and get back home to mom and dad in upper Michigan or someplace else in the State of Michigan.

Mr. WAXMAN. You expressed concern that a plan would, in effect, switch over the higher cost tertiary care to a children's hospital but not allow you to do the primary care services that you also would provide.

Couldn't you see if, from the Kaiser Permanente point of view, that if they have a clinic in the community, that they would want the people who are enrolled in that closed end HMO to come to them and not to you?

Mr. ROZEK. I could see it from their point of view from a business perspective, and I think as a reasonable negotiation process, you could prove the value is provided, not only an issue of quality but cost, but what is the value of providing the services to the child and to the family, and there that may be the case where Kaiser Permanente may in fact say to Children's Hospital, you made a reasonable case, we are not going to be in that business.

As the Henry Ford Health System which runs the largest HMO in the State of Michigan, 400,000 managed care lives, and said that they don't want to be in the pediatric cardiac business or the pediatric general surgery business. They will in fact contract with us, and when they have contracted with us, to do all those services for them.

We have done it on a price and based on some volume indicators and the kind of quality the Henry Ford Health System wants for their HMO.

Mr. WAXMAN. Let me hear from the community health centers' representatives. How do you feel about this kind of concern that is being expressed by a closed panel HMO, but it may also be a concern that wouldn't be all that different for any other network or plan or IPA.

Ms. TRICE. I guess what I would say, Mr. Chairman, it is obvious from what you have told us that Kaiser—it is not from me, first of all, with community health centers, because I think what is important to know is that for the past 30 years, the community health centers have been in operation, we have all kinds of require-

ments, quality assurance measures that we have to abide by in order to function, and first of all, I think that it needs to be known that our providers, our physicians, are all board eligible and board certified.

You can't get better than that when it comes to providing care, and I believe our record speaks for itself in terms of being cost effective. I know that community health centers provide the quality as well as the cost-effective services that any hospital, and I know that those in the Miami area are certainly talking to me and other community health centers about linking with them to work together in terms of providing services under health care reform.

Mr. GALLEGOS. Mr. Chairman, from a rural perspective, I would point out that in northern New Mexico, for example, I have a major HMO that is moving into that community, community of about approximately 13,000 people. Those HMO's have never been there.

I see HMO's beginning to emerge and positioning themselves for some type of universal coverage, managed competition. However, outside of that community, the rural areas that I serve, if you get all these people covered under that particular plan, I really don't see them out in those rural and remote areas.

I have five additional clinic sites where they are 45 miles from the local hospital, takes sometimes an hour to an-hour-and-a-half to get to that hospital and the population density is such that there is no population base there for them to move out there. Access then becomes a real problem for those folks in those communities.

Mr. WAXMAN. So you would feel that since you are the only ones out there to provide the care, that whatever health plan might want to compete, that they would be using your services?

Mr. GALLEGOS. Absolutely, Mr. Chairman. There is an infrastructure that is there. There is a facility, there are health professionals working in those areas, both family practice physicians and mid-level practitioners, clinical social workers, case managers, that are already out there, and that structure should be developed and nurtured rather than completely eliminated because I really feel that without our presence in the community, health center model out there, no HMO or managed competition is going to get out to those communities.

Those people are going to travel long distances or go underserved.

Mr. WAXMAN. Mr. Gage, you want to add anything?

Mr. GAGE. Yes. Ms. Trice was much kinder than I was, but she said the same thing about not knowing what community health centers are like, and I would echo about not knowing about what public hospitals in inner cities are like.

Frankly there is a great deal of hypocrisy in statements like you described and I won't attribute it to Kaiser in particular by any means. People simply are clueless about what goes on in the inner city and what kinds of health care are being provided there and how few physicians and hospitals and health plans have been willing to provide services in the past and are geographically able to provide services.

I often think that the hundred members of NAPA should all ban together into a national health and hospitals corporation, like one of our members once suggested, go bankrupt all together and close,

and so we will see who are going to provide those 100 million outpatient and emergency visits that I talked about.

There are going to be many, many aspects of the patient population to become insured under health reform that are still going to require the existence of inner city safety nets. We don't need all the hospitals we have in this country. We don't need all the public and private hospitals, but these institutions are way out in front in a variety of areas in terms of serving—

Mr. WAXMAN. I understand what you are saying. But look, the philosophy that this administration has adopted and others in the Congress are pushing is that we are going to let entrepreneurs run health care by putting together plans that will be profitable, and they will then have people line up—sign up with these plans and they, in one way, may theoretically give them good care, preventive and primary care; in other ways, they are happy to get the capitated amount of money in advance and not provide any care if they don't have to.

So while entrepreneurs are putting together, an arrangement to make money, they are not anxious to spend an extra amount of money on a public hospital. They are not even anxious to get the people that are in the public hospitals for care. They would rather compete for others, but they may not have a choice, so if they could take some inner city person and sign them up to go to institutions in the suburbs, which they would never be able to go to as a practical matter, that would be fine and dandy because they would probably save a ton of money which could help their profit margin.

Isn't that where we are heading? So if we want them to use public hospitals, we have got to provide some ways in this bill not to let the market just work its will. Because if the market works its will, you are going to be left out of the loop.

Mr. GAGE. We are going to be left out but actually inner city patients are going to be left out too, and we are going to go back, perhaps as in California in 1972 when physicians operated out of the backs of their Mercedes-Benz and traded toasters for medical cards and went away, never to be heard from again, and we have a great deal of concern about many aspects of unfettered competition dictating who is going to live and who is going to die in the inner city.

Mr. WAXMAN. Thank you very much. Mr. Brown, do you want to ask questions?

Well, you have raised these points that we have got to be very mindful of, and I appreciate the fact that the administration has tried to address these issues, but we need to continue to work on them to be sure that we get that right balance.

Thank you very much. We are going to recess now and reconvene in this room at 2 o'clock.

[Brief recess.]

Mr. WAXMAN. The meeting of the subcommittee will come back to order. Our next panel includes representatives of academic health centers and medical schools. Dr. Stuart Bondurant is Dean of the School of Medicine at the University of North Carolina, Chapel Hill and is currently Chairman of the Association of American Medical Colleges.

Dr. Roger Bulger is President of the Association of Academic Health Centers, and Dr. Peter Budetti is the Hirsh Professor of

Health Care Law and Policy and Director of the Center for Health Policy Research at George Washington University in Washington, DC. In addition, as many of my colleagues will recall, Dr. Budetti also served on the professional staff of this subcommittee.

We want to welcome you to our hearing today. Your prepared statements, without objection, will be made part of the record in full. What we would like to ask each of you to do is to limit the oral presentation to no more than five minutes.

Dr. Bondurant.

STATEMENTS OF STUART BONDURANT, CHAIRMAN, ASSOCIATION OF AMERICAN MEDICAL COLLEGES; ROGER J. BULGER, PRESIDENT, ASSOCIATION OF ACADEMIC HEALTH CENTERS; AND PETER P. BUDETTI, HIRSH PROFESSOR, DIRECTOR, CENTER FOR HEALTH POLICY RESEARCH, GEORGE WASHINGTON UNIVERSITY

Mr. BONDURANT. Thank you, Mr. Chairman, and Members of the subcommittee. I am Stuart Bondurant, Dean of the School of Medicine at the University of North Carolina at Chapel Hill, and Chair of the Association of American Medical Colleges.

The AAMC very much appreciates the administration's leadership in initiating legislation to extend universal comprehensive coverage while improving quality and constraining growth in health care costs.

Recognizing the complexity of this matter, we especially appreciate the attention of this committee and your leadership, Mr. Chairman, in exploring these issues further and in discovering, as we have this morning, many of the areas that clearly need further attention.

The AAMC is especially appreciative of Dr. Philip Lee and Dr. Brian Boughs, with whom we have worked closely in developing our own thinking on this matter. I would like to begin by assuring you, Mr. Chairman, and the committee that the Nation's medical schools and teaching hospitals recognize and accept the great responsibility in health care and health care reform that we have, and given the necessary tools, we are confident that we can provide two essential products.

One is a competent physician work force balance for the needs of the population of our country, and second is the knowledge and information base which is essential for health care and health care reform both. The AAMC, as you know, is interested in many issues in the Health Security Act, vitally interested in many issues, ranging from broad issues such as universal coverage to more narrow concerns, such as the provision for contracting with academic health centers.

Today, however, my comments will focus on two proposals in the Health Security Act in which these organizations play an essential role: The academic health center provisions and the workforce provisions.

Before coming to those, let me briefly say that an underlying policy in the Health Security Act is one which would require support for the missions of academic health centers from all payers. The AAMC believes that that is fundamental to the success of this—of this entire project, that all payers need to bear a proportionate

share of the costs of the academic enterprise, which in a sense is funding the depreciation of the intellectual capital of the system or funding a depreciation of the competence of our physician workforce. We applaud that principle in the bill.

Before moving on to the other provisions, I do want to call your attention to a particular major issue of concern to those of us who are responsible for producing the figures particularly, but other health provider components of the workforce in the future. Managed competition, the fundamental premise on which the Health Security Act is based, would unravel, if left uncontrolled, certainly unravel the medical school's entire financing system because of the extent to which it is dependent on cross subsidization from other sources.

In my written testimony, you will see that on page 19, 32 percent of the total revenue, the total financial support of America's medical schools comes from fee-for-service clinical practice of the clinical faculty. As competition comes to reduce those sums and especially in those areas that the academic medical centers are participating in now, the impact of that on the medical school's ability to sustain the programs that are essential for health care reform will be, in our view, very severe.

This happens particularly at a time when we are having to move our educational programs into more expensive venues, such as the ambulatory care setting where we can't realize certain economies in education that we realize when those programs are based in hospitals as differentiated from clinics or doctors' offices.

Let me move on. With specific respect to the legislation under discussion today, we agree with the need to change more physicians in the generalist disciplines. The AAMC officially adopts the position that a sound position for the country would be that at least 50 percent of all physicians should be generalists. We agree with the goal in your bill, Mr. Chairman, H.R. 1315, to that effect.

We do believe that the regulatory approach to physician workforce training might not be necessary. We believe that there are indications—there are recent indications of a substantial change in the distribution of career choices of our graduates, and we think that it would be well to have the commission observe for a year or two before it makes a final regulatory kind of a move.

We also believe that the provisions for allocating residencies among specialties needs to take into considerations matters such as those referred to this morning from New York, from the Veterans' Administration, and that those considerations will require—will best be done with some delay in that process.

We do not support the GME payments being awarded directly to training programs. We think they should be awarded to the institutions that incur the costs. I think, Mr. Chairman, that my time is up and let me stop with that and say that we welcome—again, we welcome your interests and I would be pleased to respond to any questions on anything pertaining to the written record.

Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you very much for your testimony and we do have that whole written testimony in the record.

[Testimony resumes on p. 432.]

[The prepared statement of Dr. Bondurant follows:]

STATEMENT OF STUART BONDURANT

Mr. Chairman and members of the subcommittee, I am pleased to appear before you today to comment on two proposals of particular interest to academic medicine in the Health Security Act, H.R.3600, (HSA). I am Stuart Bondurant, M.D., Chairman of the Association of American Medical Colleges (AAMC) and Dean of the University of North Carolina at Chapel Hill School of Medicine. The AAMC represents the nation's 126 accredited medical schools, 400 major teaching hospitals, the faculty of these institutions through 92 constituent academic society members, and the more than 140,000 young men and women in medical training as students and residents.

The AAMC appreciates the administration's leadership in initiating legislation to extend universal comprehensive health coverage while improving quality and constraining growth in health care costs. As early as 1969, the AAMC called for universal access to health care, and since then has advocated a number of other positions on reform of the overall system, including the need to: balance the provision of a basic benefits package with available resources; provide access to primary, preventive, and specialty care; support pluralistic financing systems with appropriate beneficiary cost sharing mechanisms; and develop planned community health care programs.

In June 1993, the association adopted a set of five goals and supporting principles that should guide health care reform. The goals are: 1) giving all Americans the chance for a healthy life; 2) providing universal access to health care; 3) recognizing that once health care excellence is achieved, the necessary resources must be provided so that quality and capacity are maintained; 4) instituting cost containment measures that do not compromise health care quality; and 5) supporting the essential roles of medical and other health professional education and of biomedical, behavioral and health services research. (Appendix A provides a complete list of goals and principles.)

Health care reform will test the entire health care system, and academic medicine in particular will face special challenges. These institutions and their faculties constitute the cornerstone of the health care system, as educators of physicians and other health professionals, creators and evaluators of scientific knowledge and its transfer into practice for the benefit of society, and major providers of primary, secondary and tertiary care in their local communities--often to indigent patients--and on regional, national and international levels. These special responsibilities are highly interdependent in both their missions and financing, and increase the costs, and therefore the price that teaching physicians and teaching hospitals must charge for their services, making it difficult or impossible for them to compete in a price conscious environment. Additionally, the contributions of academic medicine depend on multiple sources of financing, each of which is increasingly constrained. If medical schools and teaching hospitals are to sustain their roles as ultimate guarantors of the effectiveness of the health care system, health care reform must recognize the special roles these institutions play in society.

The AAMC is interested in many issues in the proposal, ranging from broad areas such as anti-trust, to more narrow concerns, such as the provision for contracting with academic health centers. There are many policies in the HSA that deserve enthusiastic support, ranging from reforming the Medicaid program to altering the malpractice system. The

AAMC is particularly pleased that the HSA recognizes the critical missions of teaching physicians and teaching hospitals in the health care system: educating physicians, research scientists and other health professionals; developing new medical technology; treating rare and unusually severe illnesses; providing specialized patient care; and caring for special populations. However, the association must call to the attention of this subcommittee and others that the HSA, as proposed, represents a severe threat to the financial viability of the nation's medical schools. Medical school financing is based on a fragile structure of internal cross subsidies; a very substantial portion of medical school expenses are borne by revenue derived from patient services provided by medical school faculty members. Managed competition, by creating a medical care market highly sensitive to price, will tend to reduce revenues available for this purpose. Simultaneously, it will demand radical shifts in educational emphasis, from specialist to generalist, from hospital to ambulatory focused care. Thus, traditional revenue generating activities will be curtailed or become less rewarding while revenue consumptive activities will increase. Faculty income promises to be reduced, while greater reliance for educational purposes must be placed on community physicians. The income of community physicians will be constrained and medical schools will be without income to compensate them for the additional contributions to professional education asked of them.

Currently, HSA makes no provision for revenue lost to medical schools, no provision for supporting costly new activities that must be undertaken and makes no allowance for a transition to a new and highly uncertain future. Thus, as a medical school dean, I and my colleagues anticipate health care reform with considerable trepidation.

The legislation's provisions for physician workforce priorities, academic health centers (AHCs), health research initiatives, health programs of the Department of Veterans Affairs (VA), and hospitals serving vulnerable populations give the association an opportunity to continue a dialogue in these areas. They are of special concern to academic medicine and are crucial to the overall viability and quality of the health care system. Today I will focus my comments on two specific provisions in the legislation: the health professions workforce and the academic health center proposals. I will then return to the theme of the financial viability of medical schools.

The HSA has an underlying policy requiring support for the missions of academic medicine from all insurers or sponsors of patient care programs. The level of financial support, the purposes for which the funds are intended, and how money is allocated are all matters that will be subject to debate. However, the AAMC wishes to emphasize the fundamental importance of the principle that all payers must support sustaining the workforce and research to improve care through academic medical centers. Our commitment to this principle will not waiver.

The Health Security Act: The Workforce Planning and Allocation Provisions

Summary of the Act. The HSA would establish a national council on graduate medical education within the Department of Health and Human Services (DHHS) to designate annually the total number of residency training positions in each specialty and allocate positions to approved training programs. The national council, to be appointed by the Secretary of the DHHS, would include consumers, medical school faculty and other practicing physicians, and officers or employees of regional and corporate alliances and health plans.

The national council would make its first annual designation of training positions in each specialty for the three-year period beginning July 1, 1998, notifying programs of their approval no later than July 1, 1997. At least 55 percent of the class entering residency training in July 1998 (and classes thereafter) must, in the aggregate, complete training in the primary care specialties of family medicine, general internal medicine, general pediatrics and obstetrics/gynecology. Thus, 55 percent of the physicians starting their graduate training in 1998-99 would complete their training at the end of the 2000-01 academic year as generalists.

For each of the academic years 1998-99 through 2002-03 (a five-year period), the national council also would adjust the total number of positions by a percentage that it would determine. The HSA states that the annual number of positions should bear a relationship to the number of U.S. allopathic and osteopathic medical school graduates in the preceding academic year.

In making its annual designation of the number of positions, the council would consider the need for additional practitioners in each specialty based on the incidence and prevalence of diseases and disorders with which the specialty is concerned; the number of practicing physicians in the specialty currently and five years from the start of the academic year; and the recommendations of physician specialty and consumer groups. The council would allocate positions based on the historical distribution and quality of training programs; the extent to which programs train under-represented racial and ethnic minorities; and the recommendations of private physician specialty and consumer organizations.

AAMC Comments on Workforce Planning and Allocation Provisions.

The Need for Generalists. The AAMC agrees with the need to train more physicians in the generalist disciplines, one of the basic principles underlying the HSA. Increasing access to the health care system for all Americans will require more generalist physicians. In 1992, the association called for a national goal of a majority of graduating medical students committing to generalist careers in family medicine, general internal medicine, and general pediatrics. This position supports the goal in the Primary Care Workforce Act of 1993 (H.R. 2804/S. 1315) of 50 percent of the total number of entry residency training positions in the three primary care specialties.

However, the AAMC believes that a regulatory approach to physician workforce training might not be necessary. Changes in market forces already are shifting the balance of generalist and specialist physicians as incentive systems are restructured, and it appears likely this trend will continue. Changes in the practice environment, namely the increase in managed care arrangements, increases in physician reimbursement for cognitive services, and mitigation of the "hassle factor" are also likely to affect medical students' career choice.

Although data on medical students' career choice from as recently as the graduating class of 1989 show a declining selection of the generalist specialties, more recent data give the AAMC and the academic medical community signs that 1993 medical school graduates have noticed the changes in the environment. This year, for the first time in more than ten years, the percentage of medical school graduates indicating their intention to pursue certification in one of the generalist disciplines increased. Of graduating medical students, 19.3 percent indicated an intent to choose a generalist career in 1993 compared to 14.9 percent in 1991 and 14.6 percent in 1992.

If, on the other hand, an all-payer fund for the costs of training the physician workforce is created and analysis has shown that market forces have not been effective in shifting the balance of generalist and specialist physicians and in achieving appropriate goals for the total number of residency positions, then the AAMC would support a regulatory approach to physician training. A national commission or council could assume responsibility for authorizing payment from the fund for the costs of graduate medical education to assure that national goals are met.

The Need for a Planning Process. The AAMC recognizes the need for a permanent and continuous physician workforce planning process at the national level. The successful implementation of health care reform rests upon an adequate supply of well-trained health professionals in an appropriate specialty mix that addresses the needs of the population.

The association supports the creation of a national physician workforce council or commission, authorized in statute, that would be composed predominantly of private citizens representing various constituencies with interests in physician education. However, we strongly support the addition of medical school deans and teaching hospital executives to the membership of the HSA's proposed national council. The administration's proposal does not now include these categories for representation.

We also believe that the national council should be independent of the Department of Health and Human Services and funded separately from the workforce account. The AAMC is currently considering options for how the council or commission could be structured and organized. Our concerns are whether this body would be advisory or the locus for all responsibility concerning graduate medical education and whether the council would be insulated appropriately from attempts to influence its decisions. Additionally, the council would need sufficient funding and staff to permit its effective operation.

The AAMC is concerned that the timetable for making the council operational may be too ambitious. The HSA requires that training programs would have to be notified of their approval by July 1, 1997. If the HSA were signed into law in August 1994, the national council would have less than three years to establish and organize itself, adopt broad principles and policies for change, and make thousands of allocation decisions.

Determination of the Number and Allocation of Residency Positions. As in the HSA, the association endorses no specific number or limit on the total number of positions, but expects training capacity to relate to projected physician need and the number of U.S. allopathic and osteopathic medical school graduates. The AAMC believes that the commission should assess physician workforce needs and provide guidance for setting goals for the total number and specialty mix of residency positions. We agree with the administration that in designating the annual number of positions, it would be desirable to consider the current and future distribution of practicing physicians, and the incidence and prevalence of diseases associated with particular specialties, among other factors.

The AAMC believes that implementing the achievement of the 55/45 ratio by the year 2001-02 is much too aggressive. As currently described in the HSA, the national council would adjust the specialty mix of first-year positions for the 1998-99 entering residency class, which would be required, in the aggregate, to complete their training in a 55/45 generalist-to-specialist ratio by 2001-02.

The AAMC also is concerned that the timetables for allocating positions by specialty and for adjusting the total number of residents are poorly coordinated and are too rapid to permit institutions to adjust their training program size and mix. At the same time the council would adjust the specialty mix of first-year positions to a 55/45 generalist-to-specialist ratio, the council also would begin to reduce the total number of residents in 1998-99 for the first reduction over a five-year period (through 2002-03). Assuming a policy of first-year positions equal to 110 percent of U.S. allopathic and osteopathic medical school graduates, the national council would be placed in the position of advocating or directing an increase in the number of generalist positions, only to have to eliminate some of them later to achieve a reduction in the overall number of first-year residency positions.

Table 1 below uses current (1992-93) data to demonstrate how the number of generalist and specialist first-year positions would change if this limit were placed on the total number of residency positions. In this example, the overall limit is 18,660 positions, roughly the number of graduates of U.S. allopathic and osteopathic medical schools plus ten percent. The number of first-year generalist positions would have to be increased dramatically in 1998-99, but then would have to be decreased to limit the overall number of positions to 110 percent, while maintaining the 55/45 generalist-to-specialist ratio. This example assumes that the 110 percent goal of 18,660 first-year positions would be reached in 2002-03 through a gradual, annual reduction of about 850 positions over a five-year period beginning with the 1998-99 entering residency class.

Table 1
An Example of Adjusting Total First-Year Residency
Training Positions: Reducing the Total Number to 110 Percent of 1992-93 Graduates
While Maintaining a 55/45 Ratio of Generalists to Specialists

	Current (1992-93) Filled First-Year Positions	—	1998-99	1999-2000	2000-01	2001-02	2002-03
Total	22,905	—	22,056	21,207	20,358	19,509	18,660***
Generalists*	7,817**	—	12,131	11,664	11,197	10,730	10,263
Specialists	15,088	—	9,925	9,543	9,161	8,329	8,397
LCME + Osteo Grads + 10 %	18,662	—					

*Generalists include residents in family medicine, general internal medicine, general pediatrics and obstetrics/gynecology.

**AAMC estimate of PGY-1 trainees likely to complete training as generalists; proportion applied to current PGY-1 data based on experience of recent years, i.e., outcomes at the conclusion of residency training.

***18,660 total positions in 2002-03 used in this example as the target reflect the recommendations of the Council on Graduate Medical Education and the Physician Payment Review Commission that the total number of positions be reduced to 110 percent of graduates of LCME and AOA approved medical schools.

Source: Association of American Medical Colleges Tracking Survey, SAIMS Database, 1993.

Although the AAMC recognizes that there is an immediate need to adjust the size and specialty mix of the physician workforce, the training period for physicians is long. Any adjustments in aggregate and in specialty-specific training capacity should be carefully planned and coordinated so that the quality of the educational experience will not diminish and that teaching hospitals and training programs will be able to adapt to the requirements of the new system. One way to limit the number of residents and shift the specialty mix would be to encourage voluntarism among the specialties. The national council, early in its operations, could designate national goals or targets for each specialty. The private sector would then be able to determine its own methods for reaching the goals. Whether the specialties could meet these targets in a hostile legal environment, however, is unclear. Particularly in the area of workforce planning, and in many other areas as well, where societal needs might be better and more efficiently met by a coordinated effort among academic institutions and health care organizations, the watchful eye of the antitrust enforcers of the Federal Trade Commission and the Department of Justice casts a pall over the potential for joint endeavors. Wherever institutions, professionals, or professional societies might be regarded as actual or potential economic competitors, the current state of the law, perversely, precludes private sector efforts, and forces constructive initiatives to be the sole province of government. Thus, to accomplish its objectives, the HSA must address

legislatively the boundaries of anti-trust law and its enforcement in the health care arena.

If an allocation methodology is necessary, however, the AAMC proposes that the timetable as described in the earlier draft version of the HSA is more reasonable, providing institutions with the opportunity to adjust their training program size and mix and allowing time for market forces to shift the balance of generalists and specialists. As described in the earlier draft version of the HSA, 55 percent of the class that enters residency training in academic year 2002-03 would be required to complete their training in generalist disciplines. The council would reduce the total number of residents by a percentage for each of the academic years 2003-04 through 2007-08. The provision of a transition period from 1998 until 2002 would give institutions the flexibility to determine how to achieve the phase-down or closure of a training program as long as they achieved the goal by the end of the three- to seven-year time period depending on the specialty.

The national council could inform institutions and training programs of the size and mix targets that should be met by the end of a determined period, rather than annually, so that they could devise and implement their own strategies for adjusting training program size and mix. A series of annual decisions over a five-year period would cause significant disruption and uncertainty by requiring institutions to respond incrementally. While adoption of the timetable in the earlier draft would mean aggregate changes in the number of residents would not be completed until 2007-08, compared to 2002-03 in the current version, we believe this method would be a better approach than the current version of the HSA, both for the nation's workforce planning process and for current sponsors of training programs.

If an all-payer fund has been established and the academic medical community agrees to accept an allocation process because market forces have not had an adequate impact on shifting the balance of generalist and specialist physicians, the AAMC would support a process in which allocation decisions by specialty would be based on a variety of factors. Among the factors in the HSA are the historic geographic distribution of training programs, quality, underrepresented minority groups, and the recommendations of private health care and consumer organizations. The AAMC believes that educational organizations and associations, which often collect and analyze data on graduate medical education and other relevant topics, could make meaningful recommendations to the council concerning the allocation of residency positions.

Even so, an equitable allocation system will be difficult to achieve. The structure of graduate medical education is complex. Graduate medical education is the period of formal education in clinical practice that begins with graduation from medical school and ends with the fulfillment of the requirements for certification in specialty or subspecialty practice. The training period for physicians is long. Each of 82 specialties and subspecialties has its own training requirements, and there are nearly 7,000 training programs. Any allocation system must be flexible. For example, some specialties or programs require residents to enroll first in a broad-based clinical year of training, often in internal medicine or pediatrics, before entering specialty training. Other trainees, about 6.5 percent of all first-year residents in

1992-93, may enter a first-year residency experience, often referred to as a transitional year, to obtain a broad-based clinical year because they may be undecided about their future discipline. How to count the first, and in some unusual cases a second, transitional year will become an important issue in how positions get allocated by specialty. Other trainees may not complete their training within the minimum required time because they train part-time, share a residency position, interrupt their training for childbearing or other reasons, or change the discipline in which they train. The allocation system must be designed to accommodate these factors.

A review of the concentration of specialties and location of training reveals some important points which can be understood by reviewing Tables 3-7 at the end of this testimony. While the majority of residents are concentrated in a relatively small number of specialties and states, the remaining residents are widely distributed. Residents, training in 25 specialty and 57 subspecialty areas, are concentrated in a relatively small number of specialties. Table 3 shows that nearly one-half of all physicians in training are in the specialties of internal medicine, pediatrics and surgery. Residency training programs are unevenly distributed across the nation. Table 5 shows that while 48 states have some residents in training, one-half of all residents are trained in seven states. With this heavy concentration but broad dispersion of residents, policy makers will have to consider carefully the impact of proposed policies on both the large concentrations as well as the broader distribution in designing an allocation system.

While the AAMC concurs that quality should be a major factor in the allocation process, the association has several concerns about the process for stratifying training programs by quality. One is that there would have to be a process in place by which new training programs could enter the system. In addition, there would need to be a process to address fluctuation in individual program quality across years. Educational quality is dynamic. The process and incentives must be in place to motivate the program to improve its quality continuously, rather than simply taking a snapshot of educational quality. Finally, one must make the distinction between the significant reductions in positions that are likely to occur in the first five years after the proposed legislation is passed compared to the continuous monitoring of educational quality that will be needed in later years. The decision of whether to eliminate a training program entirely or whether merely to reduce the size of the existing program may require very different approaches.

A large number of professional organizations participate in graduate medical education to provide control over the quality of the training. They determine the standards to be met by each type of specialty training program and assess whether or not individual programs meet the standards. The Accreditation Council for Graduate Medical Education (ACGME) accredits nearly 7,000 graduate medical education programs in the United States. It is sponsored by five parent organizations, including the AAMC. The ACGME relies on residency review committees (RRCs) to perform the actual review of each training program. A RRC consists of representatives from the specialty appointed by the appropriate specialty board, and in some cases, a national specialty society, and the American Medical

Association. Residency programs are accredited either by the ACGME upon recommendation of the RRC or by the RRC itself, if the ACGME has delegated authority to it.

Some policy makers have suggested that the ACGME or the American Osteopathic Association's Committee on Post-doctoral Training, which would be separate from the proposed national council, should assume the additional and sole responsibility of allocating positions on the basis of measures of educational quality. The association believes that the medical profession should judge the quality of its training programs, but it has several concerns about the ACGME's ability to differentiate and stratify training programs by educational quality. For example, it is unclear whether the ACGME has the information systems or methodology to quantify educational quality objectively beyond established minimum criteria. To rank training programs would be highly subjective. In addition, the structure and resource level of the ACGME may be inadequate to undertake this role. Developing and implementing a mechanism to stratify programs by quality certainly would require more staff and financial resources than the ACGME currently has at its disposal. It is also clear that, if the ACGME were to take on the role of ranking training programs by quality, it and its five sponsoring organizations would need significant legal protection. The ACGME relies almost wholly on contributed professional time. Thus, it is not structured to command the resources to deal with the inevitable legal challenges to a ranking process that will accumulate over time. The role of quality in the allocation process and the method of measuring program quality are difficult issues. While the AAMC's current position is that the ACGME should not assume responsibility for allocation or ranking, the association also recognizes that there are strong arguments favoring some greater level of participation by the ACGME in an allocation process. The AAMC, along with other sponsors of the ACGME, is currently evaluating an ACGME proposal on how the ACGME could effectively and appropriately participate in allocation activities.

The AAMC strongly supports considering underrepresented minority groups in position allocation decisions. The association has implemented an initiative aimed at increasing the number of underrepresented minorities who apply to medical school. Called 3000 X 2000, our goal is to have 3,000 individuals in underrepresented minorities apply to U.S. medical schools in the year 2000.

The AAMC believes there are a variety of allocation approaches to study. We hope that the HSA provides the national council with the flexibility to examine a number of national, regional and local approaches. Dr. Lee and his staff have been very gracious in consulting with the AAMC on this and other workforce issues. We have provided data on residency training to the Public Health Service in the Department of Health and Human Services and hope to continue working with Dr. Lee's representatives to help them refine their proposals. Before I comment further on the workforce provision, I would like to address the overall financing adequacy of the workforce and academic health center provisions.

The Health Security Act: Summary and General Comments on Financing Provisions for the Workforce and AHC Accounts

Summary of the Act. The HSA would recognize the critical roles of academic medicine in the health care system by creating two funds. The physician workforce account would assist in the funding for the institutional costs of graduate medical education; the academic health center (AHC) account would assist these institutions and teaching hospitals in covering the special costs they incur as part of their academic mission. Both funds would be separate from patient care revenue and, according to the administration's December 1993 analysis of the HSA, three sources--the Medicare program, regional health alliances and corporate alliances--would be required to contribute to both funds.

AAMC Comments on Overall Financing.

The AAMC is pleased that the HSA recognizes that teaching hospitals and teaching physicians are unique national resources and that they have added societal responsibilities in the health care system. The association strongly supports the need to fund separately the spectrum of costs associated with an academic mission, including the costs of graduate medical education and other health professionals, and the special and unique patient care costs that make it difficult for these institutions to compete in the current environment. We also agree that all payers should contribute to the financing of both accounts.

However, the AAMC is concerned about the level of the financing of the two accounts and how the funds are distributed. Overall, the amount available to fund these costs is insufficient. Proponents of the HSA have argued that, if enacted, teaching hospitals would be better protected and more adequately financed than if the current situation were maintained. They compare the current level of Medicare payments for direct graduate medical education and indirect medical education costs--nearly \$6 billion in FY 1994--to the \$9.6 billion total amount that teaching hospitals would receive in the year 2000 under the HSA. In addition, many HSA-proponents believe that teaching hospitals will be able to "make up the difference" by commanding premium prices in the delivery system based on their service offerings and reputations.

While the total of these set-aside funds would exceed current Medicare spending for direct graduate medical education costs and the indirect medical education (IME) adjustment, this premise indicates an apparent misunderstanding of the current competitive environment and the level of support that the academic mission requires. The Medicare program supports only a portion of the academic mission. Data from hospitals belonging to the AAMC's Council of Teaching Hospitals show that Medicare payments cover only about 20 to 33 percent of the costs associated with the academic mission. The other 67 to 80 percent must be obtained from public and private payers who provide the balance of funding for these additional costs primarily through increased charges for services.

Historically, teaching hospitals have financed their multiple functions through cross-subsidization. For example, patient service revenues have supported graduate medical education and other academic activities; routine service revenues have supported tertiary care patients; revenues from high volume services have supported low volume services; and payments from paying patients have supported charity care patients. However, during the past few years, as the overall costs of medical care have risen sharply, private health care payers have adopted payment systems--such as capitation, aggressive contracting and discounting--that restrict their payments to cover only goods and services they believe are necessary and of identifiable benefit to their enrollees. Costs associated with the education and research missions of teaching hospitals generally are not recognized by these payers.

In the newly price competitive environment, there is pressure to identify the cross-subsidized products of teaching hospitals. The AAMC believes that teaching hospitals will no longer be able to "make up the shortfall" to fund the costs associated with their academic missions through higher charges to patients. Therefore, the overall financing of the two funds must be adequate to ensure the continued financial viability of these institutions.

Notwithstanding these comments on the overall adequacy of the two provisions, the AAMC has several specific comments about the financing of the workforce and academic health center (AHC) accounts and about the need to address some technical issues.

The Health Security Act: Financing of the Health Professions Workforce Account

Summary. Payments for operating a residency training program and transitional payments to institutions that lose residency positions would be made from a federal health professions workforce account. The account would be funded at \$3.2 billion in Calendar Year (CY) 1996, the first-year of implementation; \$3.55 billion in CY 1997; \$4.8 billion in CY 1998; and \$5.8 billion in CY 1999 and CY 2000. In subsequent years, that amount would be increased by the general health care inflation factor. Medicare payments for the direct costs of graduate medical education would terminate for cost report periods beginning on or after October 1, 1995. Beginning in Federal FY 1996, Medicare would contribute to the workforce account: \$1.5 billion in FY 1996; \$1.6 billion in FY 1997 and FY 1998; and after 1998 the \$1.6 billion would be increased by the consumer price index. According to the administration's December 1993 analysis of the HSA:

after the level of Medicare payments is determined, corporate and regional alliances pay the balance needed in the annual health professions workforce account, with such payments coming from the 1 percent corporate alliance assessment (under section 7121) and the 1.5 percent regional alliance assessment (under section 1353). For 1996 and 1997, one-half of such regional alliance payments are available for the annual health professions workforce account, with the remainder made available from payments by corporate alliances. In subsequent years, payments into the annual health professions workforce account are made in proportion to the total payments to corporate and regional health plans by corporate and regional alliances, respectively (Page 112).

Workforce payments in any year would be pro-rated if necessary on the basis of available funds. Starting in CY 1996, training programs that have applied and have been approved for payments would receive them directly from the Secretary of the DHHS. Calendar years 1996 and 1997 would be transitional years during which some states would not participate in the HSA. All states would be participants by CY 1998. In 1996 and 1997, the Secretary would first make payments to those programs located in participating states. Programs in non-participating states would receive pro-rated payments from the remaining funds in the workforce account.

Training programs would have to apply and be approved for payment and then would receive funds directly. Programs would submit applications to the Secretary of the DHHS for approval. Programs must agree to spend workforce funds only for the purpose of physician training. The institution within which the program operates would be required to agree that payments would be made directly to the program by the Secretary.

Payments would be calculated using the national average cost for training residents multiplied by the number of full-time equivalent residents in the program. The national average cost would be determined using the 1992-93 academic year, trended forward by the consumer price index (CPI) for each year, and adjusted to reflect regional differences in wages and wage-related costs. The national average cost of training would consider the national average salary of residents and the national average cost of providing faculty supervision and related activities.

Beginning in CY 1997, "transitional payments" to assist institutions that lose residency positions would be made from the health professions workforce account, subject to the availability of funds. The payment would be determined by multiplying the aggregate number of full-time equivalent positions lost by the national average salary of residents in 1992-93, updated by the CPI and adjusted for regional variation. The payment would be available for a four-year period, starting in the year in which an institution has fewer positions than during the 1993-94 academic year. Institutions may apply only once to receive the funds. For the first-year in which an institution would be eligible, the payment would be 100 percent of the national average salary, and would be reduced by 25 percent in each of the three subsequent years.

AAMC Comments on Workforce Financing

The AAMC has adopted the position that all payer financing of graduate medical education must accompany the establishment of a regulatory process for allocating residency positions if a national commission determines that market forces have failed to shift the balance of generalists and specialists. Upon creation of an all-payer fund for the costs of graduate medical education, the national commission would determine whether the medical education community has made adequate progress toward achieving its goals. If adequate progress has been made, there would be no need for the national commission to control the allocation of positions through a regulatory process, but a mechanism for distributing payments from the

all payer fund would still be needed. However, if adequate progress has not been made upon establishment of the all payer fund, the commission could assume responsibility for authorizing payments for the costs of GME, and could develop and implement strategies to assure that the national goals are achieved.

The AAMC is concerned that the amount of money in the workforce account is not adequate. This account does not include financing for the 8,500 residency positions which are currently funded by the Department of Veterans Affairs. It also appears to exclude payments for podiatry, oral surgery or general dentistry residents, for whom the Medicare program currently pays its proportionate share. In addition, the dynamics of how the regional and corporate alliances would participate in financing these costs are not well understood, including how these entities contribute to both the workforce and the AHC accounts and at what level.

Even more troubling is that the overall level of the fund--\$5.8 billion in CY 2000 (which has not been adjusted for inflation to the year 2000)--is determined using a national average per resident amount which includes no overhead costs. It is our understanding that the aggregate funding needed for this account was estimated using only the national average resident's stipend and fringe benefits and an average salary and fringe benefit amount for faculty supervision.

The AAMC believes the level of payment should recognize all types of costs, including direct overhead costs, such as malpractice costs, classroom space and clerical support, and is concerned about the adequacy of the proposed national average payment which excludes overhead costs. The AAMC also is concerned about the use of a national average payment methodology and its redistributive effect across institutions. The overall financing of teaching hospitals and medical schools often is driven by historic circumstances, which have led to certain costs, especially faculty costs, being borne by the medical school, or in some cases, the teaching hospital. The diversity of faculty costs is probably the most important reason for the variation in Medicare per resident payments. Additionally, there are legitimate differences in educational models depending on the specialty and the institution. Residency programs also may have unique histories and differences in the funding available to them, such as state or local government appropriations. While the HSA requires the national average payment to be adjusted to reflect regional differences in wages and wage-related costs, these other structural factors would not be reflected in the HSA's proposed national average payment methodology, creating winners and losers inappropriately.

At its January 20, 1994 meeting, the Prospective Payment Assessment Commission (ProPAC) discussed recommendations on graduate medical education financing for its March 1994 report. Commissioners reviewed a staff analysis of graduate medical education costs and payments and noted the complexity of the distribution of these payments to hospitals. Chairman Stuart H. Altman, Ph.D., cautioned those who prefer moving to a national average payment methodology for residency costs without incorporating a number of adjustments in the payment system. Pointing to the commission's eleven-year experience with the

prospective payment system--the first attempt by the federal government to standardize payments based on national averages--Dr. Altman noted how many adjustments had been added to the PPS over the years to achieve payment equity. ProPAC's preliminary analysis of graduate medical education costs found significant positive relationships between per resident costs and hospital size; its share of full-time equivalent residents in the outpatient setting; its share of costs related to faculty physicians' salaries; geographic region; location in a metropolitan statistical area; and area wages.

The AAMC believes that since the HSA imposes an overall limit on the amount available for workforce funding, other payment policy options, which would distribute the funds more equitably among training sites, should be explored. The AAMC intends to pursue the development of alternative payment proposals that would recognize the significant diversity across institutions that participate in graduate medical education. We would be pleased to share our payment policy proposals with members of the subcommittee and with the administration.

The AAMC believes that some institutions may be unduly harmed financially during the transition years of 1996 and 1997, when some states would not yet be participating in the HSA and would therefore receive pro rated payments from the balance in the workforce account. It would be possible for the entity to receive a smaller payment in 1997 than it did in 1996. The AAMC believes that language should be added to the bill so that training entities would not receive less than they did in 1996, or less than they would have received from the Medicare program.

The AAMC understands that there is an error in the bill regarding the funding level of the workforce account in CY 1998. At \$4.8 billion, it is funded at \$1 billion less than it should be funded. CY 1998 would be the first-year in which all states would participate in the new system. Thus, a fully-funded workforce account of \$5.8 billion in CY 1998, and updated for inflation in CY 1999, would be essential.

Another correction needs to reflect the transition between the end of Medicare payments for direct graduate medical education costs and when payments from the workforce account would begin. As currently written, Medicare payments for these costs would terminate for cost reporting periods beginning on or after October 1, 1995. There may be a gap in available funding depending on the timing of the contributions.

The AAMC does not support payments being awarded directly to training programs. The association believes that payments from the workforce account should be made to the entity that incurs the cost. Recipients of payments could be teaching hospitals, medical schools, multi-specialty group practices or organizations that incur training costs. The AAMC strongly encourages the formation of formal associations, or graduate medical education consortia, to assure the continuity and coordination of medical education and to serve potentially as the fiscal intermediary in distributing payments across various training sites.

The AAMC agrees that transition payments should be available to institutions that lose residency positions. However, the association is concerned about their timing and their adequacy. To encourage institutions to adjust the size and mix of their training programs, transition funds should be made available as soon as the national council is operative. The HSA now states that these payments would not be available until CY 1997. Additionally, there should be some flexibility in how these payments are used so that institutions could try different approaches. The AAMC also is concerned that because an institution could apply only one time to receive payments, it would be locked into a four-year period during which it could become even more disadvantaged if further reductions in positions were imposed after the institution's application. Additionally, because these payments would be determined using only the national average salary of a resident, they may not provide enough relief. Some hospitals may still be unable to attract highly skilled non-physician practitioners or community physicians as substitutes for residents, particularly in inner city areas.

We support the funding for other health professionals-nursing and allied health-through the continuation of Medicare hospital payments and through other authorized programs. How the costs of training general dentists, oral surgeons and podiatrists are paid under the HSA's plan is not clear. Currently the Medicare program pays their costs through the physician per resident payment amount. We believe the HSA language should be clarified as to how these trainees are funded.

The Health Security Act: The Academic Health Center Account

Summary of the Act. The HSA would require the federal government to make payments to academic health centers and teaching hospitals to "assist eligible institutions with costs that are not routinely incurred by other entities in providing health services, but are incurred...by virtue of the academic nature of such institutions."

The Act defines an "academic health center" as an entity that operates a school of medicine or osteopathic medicine; operates or is affiliated with one or more other health professional training schools or programs; and operates or is affiliated with one or more teaching hospitals. A "teaching hospital" is a hospital that operates an approved physician training program. To be "eligible" for payments from this account, institutions must apply each year to the Secretary of the DHHS and be "qualified" AHCs or "qualified" teaching hospitals. A "qualified" AHC operates a teaching hospital; a "qualified" teaching hospital is any teaching hospital other than one operated by an AHC. Payments could be in the form of a grant, contract or a cooperative agreement.

Total available amounts for payments would be \$3.1 billion in CY 1996; \$3.2 billion in each of CYs 1997 and 1998; \$3.7 billion in CY 1999; and \$3.8 billion in CY 2000, after which that amount would be updated by the general health care inflation factor in each subsequent year. As in the workforce account, AHC funds would be derived from three sources: Medicare, regional and corporate alliances. On October 1, 1995, Medicare indirect medical education payments under the prospective payment system would terminate and the program

would contribute \$2.1 billion to the AHC account. In each of Federal Fiscal Years 1997 and 1998 the Medicare program would transfer \$2.0 billion to the AHC account, and in each subsequent year that amount would be increased by the CPI for all urban consumers and transferred to the account. As in the workforce account, regional and corporate alliances would make up the balance in the annual AHC account. For CYs 1996 and 1997, one-half of the 1.5 percent regional alliance assessment would be available with the remainder to be made available from payments by corporate alliances. The alliance contribution would increase based on the proportion of the population assumed to be in the new system.

Funds would be distributed among AHCs and teaching hospitals in proportion to the product of the institution's annual gross receipts for inpatient and outpatient care and the indirect teaching adjustment factor applicable to patients discharged from the center in the preceding year or in CY 1997. No later than July 1, 1996, the Secretary must submit a report to Congress with recommendations for modifying the allocation policies to eligible institutions. In making recommendations, the Secretary is to consider the costs incurred by eligible institutions.

AAMC Comments on AHC Financing and Technical Issues

While the AAMC is pleased that the HSA would create a separate fund for the costs associated with the academic mission, the legislative language in the bill causes confusion regarding the purpose of the funds and creates expectations that are not forthcoming in terms of which entity gets the payment. Much of the confusion arises from comparing this fund and its rationale with the indirect medical education (IME) adjustment and its purpose in the Medicare prospective payment system. The confusion is only compounded because the Medicare program eliminates the IME adjustment beginning in Federal FY 1996 and then contributes funds to the academic health center account. However, the purpose of the academic health center account—reduced productivity of faculty, uncompensated costs of clinical research and exceptional costs of specialized treatment—differs from the broad rationale behind the Medicare IME adjustment for inpatient hospital costs:

This adjustment is provided in light of doubts...about the ability of the DRG case classification system to account fully for factors such as severity of illness of patients requiring the specialized services and treatment programs provided by teaching institutions and the additional costs associated with the teaching of residents...the adjustment for indirect medical education is only a proxy to account for a number of factors which may legitimately increase costs in teaching hospitals (House Ways and Means Committee Report, Number 98-25, March 4, 1983, and Senate Finance Committee Report, Number 98-23, March 11, 1983).

The AAMC suggests that the complete range of purposes of the AHC fund as described in the bill, which we assume to be examples rather than definitions of academic costs, along with the spectrum of costs associated with the academic mission, should be studied and incorporated in the Secretary's report to Congress. The AAMC believes that the due date as

specified in the HSA, July 1, 1996, is too early, given the ambitious nature of the study, and should be changed to July 1, 1998.

A second point of confusion surrounds the definitions in the bill and the issue of what entity receives the AHC payment. Some definitions, such as the use of the term "operates," need further clarification. As stated in the bill, hospitals must "operate" training programs to receive payments from this account, but hospitals that participate in affiliated programs assumedly would not receive payments. There is no definition of "affiliated with" in the bill.

The AAMC has major concern that the AHC pool is seriously underfunded at \$3.8 billion (unadjusted for inflation) in the year 2000. While the intent of this fund is to provide assistance to academic health centers and teaching hospitals in "leveling the playing field" so that they may compete on a price basis with non-teaching providers, the size of the fund is insufficient to narrow the gap to a level where teaching hospitals and teaching physicians could expect to compete reasonably. Teaching physicians and hospitals recognize that, like all other providers, they will need to become more efficient in a competitive delivery system. However, an analysis of hospitals' costs per case in the eighth-year of the Medicare PPS (1991), conducted for the AAMC by Lewin-VHI, Inc., showed teaching hospitals on average were 32 percent more costly (excluding direct graduate medical education costs) relative to non-teaching hospitals. Lewin-VHI estimated that a level playing field between teaching and non-teaching hospital inpatient costs per case would have required funding from all payers of \$7.0 to \$8.3 billion in 1991, depending on the regression model used in the analysis.

However, the HSA requires payments to be calculated using inpatient and outpatient "gross receipts." Preliminary results from Lewin-VHI's analysis showed that an all-payer fund for the inpatient and outpatient costs of teaching hospitals would have had to be funded at \$9.0 to \$10.6 billion in 1991, significantly more than the \$3.8 billion planned for CY 2000, to address adequately the costs associated with the academic mission. The AAMC would be pleased to share the results of this analysis with the members of this subcommittee as the models and data are refined.

The AAMC has serious concern that the Medicare contribution to the AHC account would be lower than statistical analysis of the differences in inpatient hospital costs warrants. The HSA would reduce substantially the current IME payment formula to a rate of about 3.0 percent for every 0.1 percent increase in a hospital's intern and resident-to-bed ratio (IRB) beginning October 1, 1995, when the program would contribute \$2 billion to the AHC fund. Current Medicare IME payments are expected to be about \$4.2 billion in Federal FY 1994. The AAMC is unaware of any analysis that justifies the proposed level of reduction in the operating cost IME adjustment. The association views the proposed reduction in the IME adjustment as simply a mechanism for lowering Medicare's contribution to the AHC fund.

The AAMC also is concerned about using the Medicare resident-to-bed formula to allocate the fixed amount of money on a pro-rated basis to eligible institutions, which in effect pays institutions at a lower rate than 3 percent. Analysis presented by ProPAC staff at the

commission's January 20 meeting found the distribution of AHC funds using the Medicare IME formula on a proportional basis to the maximum allowed by the bill resulted in an IME adjustment of 1.4 percent.

The AAMC is very concerned about the elimination of the IME adjustment as of October 1, 1995. These Medicare funds, which are essential to assuring that Medicare beneficiaries and others have access to services provided by teaching hospitals, would be reduced and removed from the PPS and then redistributed without knowing the impact on teaching hospitals' financial status. The AAMC urges the Congress to reflect carefully on this consequence when considering any change in the level of the IME adjustment, particularly until a new system is fully operational and the effect of the new system on the financial viability of teaching hospitals can be determined.

The AAMC believes that the methodology of using the IRB to distribute AHC dollars unfairly penalizes a teaching hospital that is exempt for the prospective payment system. Presumably its IRB is zero. One remedy to this oversight may be to calculate IRBs for these hospitals as if they were subject to the PPS.

Medical School Financing in an Era of Health Care Reform

Notwithstanding our specific comments on the workforce and AHC proposals, there is another issue of major concern to the academic community about which policy makers should be aware. Managed competition, the fundamental premise on which the HSA is based, would unravel medical schools' entire financing system of cross-subsidization, but would make accommodation for only a portion of the system by replacing it with two funds. The Health Security Act recognizes only academic costs that are already paid in the Medicare payment system, but fails to address the financial cross-subsidies of medical schools by offering no substitution for lost funds. The AAMC is concerned about the ability of medical schools to continue to support physician education, particularly at a time when medical schools and teaching physicians are being called on to transform the medical education system from one that focuses on specialist training in hospital inpatient settings to a more expensive system of generalist training in ambulatory, non-hospital sites.

Like teaching hospitals, medical schools, to a significant degree, finance educational and research activities through a complex system of cross-subsidization. Education, research and patient care exist as joint products. Undergraduate medical education is supported partially and directly by tuition and fees and state appropriations (primarily at public institutions). Table 2 on the following page shows that these sources of support accounted for a relatively small share (17 percent) of total medical school revenues in 1991-92.

Research is supported partly by federal and local grants and contracts. Philanthropic support supplements these sources, but by themselves these funds remain insufficient. The current educational and research output of the nation's medical schools relies on significant revenues from the delivery of medical services by the faculty of the school. Medical service revenue,

TABLE 2
REVENUES
U.S. MEDICAL SCHOOLS
(DOLLARS IN MILLIONS)

	1980-81		1991-92	
Fully Accredited Schools	116		126	
Number of Schools Reporting	123		126	
	Amount	% of Total	Amount	% of Total
GENERAL OPERATING REVENUES*				
Federal Appropriations	57	0.9%	105	0.5%
State & Local Government Appropriations	1,351	20.8%	2,662	11.5%
Appropriations	1,252	19.3%	2,523	10.9%
Subsidies	99	1.5%	139	0.6%
Recovery of Indirect Cost	445	6.9%	1,516	6.5%
Federal Government	409	6.3%	1,309	5.7%
State & Local Government	10	0.2%	32	0.1%
Non-Government	26	0.4%	175	0.8%
Medical Service Plans	1,020	15.7%	7,505	32.4%
Tuition and Fees	348	5.4%	955	4.1%
Endowment (1)	110	1.7%	401	1.7%
Gifts (2)	46	0.7%	509	2.2%
Parent University Funds	113	1.7%	208	0.9%
Reimbursements from Hospitals	404	6.2%	2,640	11.4%
Miscellaneous Sources	172	2.7%	957	4.1%
Total General Operating Revenues*	4,066	62.7%	17,458	75.4%
GRANTS AND CONTRACTS				
Research	1,340	20.7%	3,705	16.0%
Federal Government	1,098	16.9%	2,787	12.0%
State & Local Government	21	0.3%	101	0.4%
Non-Government	221	3.4%	817	3.5%
Teaching & Training	397	6.1%	533	2.3%
Federal Government	277	4.3%	317	1.4%
State & Local Government	35	0.5%	67	0.3%
Non-Government	85	1.3%	149	0.6%
Service & Multi-Purpose	491	7.6%	763	3.3%
Federal Government	124	1.9%	181	0.8%
State & Local Government	265	4.1%	362	1.6%
Non-Government	102	1.6%	220	1.0%
Research & Teaching/Training Programs at Affiliate Institutions	188	2.9%	688	3.0%
Total Grants and Contracts	2,416	37.3%	5,689	24.6%
TOTAL REVENUES	6,482	100.0%	23,147	100.0%

(1) Includes unrestricted and restricted endowment
(2) Includes one provisionally approved school

* Detail may not add due to rounding.

SOURCE: LCME Questionnaire, Part I-A, Section for Operational Studies.

which includes clinical faculty practice plan revenues, medical school activities in teaching hospitals, and grants and contracts for medical service, has increased since 1981-82 from 30 percent of total revenue to 47 percent in 1991-92. Education also benefits from an elaborate system of nonpaid voluntary faculty drawn from the community.

For several reasons, medical schools will have difficulty sustaining this elaborate system undergirding the education and research missions. Federal support is increasingly constrained, with medical schools expected to accept a greater share of the costs. Pressures brought to bear on medical service costs will likely lead to declining income from the faculty clinical practice, and less money available to support educational and research efforts. In order to preserve the patient base critical for medical education and research, faculty physicians are being drawn into developing networks with affiliated teaching hospitals and are being asked to accept capitated or discounted payments from private payers. As community physicians are forced to align with various health plans in integrated networks, their willingness to "contribute" teaching services may even be threatened.

Undergraduate medical education in the clinical setting, directed by the medical school, is not recognized explicitly by any payment system, but like other academic costs, it has been financed indirectly. The shift to a more explicit financing system threatens the ability of medical schools and teaching hospitals to fund this activity through other sources of support. Once payments for graduate medical education and unique patient care costs are made separately, they will no longer support the added cost of training undergraduates in clinical settings, particularly in non-hospital-based, ambulatory sites. In addition, funds from physicians' clinical incomes and biomedical research support cannot be expected maintain their current levels. Fundamental forces are causing the traditionally cross-subsidized products to rise to the surface, yet only in two arenas has the HSA provided assistance. The AAMC believes that a complete and adequate financing system for academic medicine must be provided and we would be pleased to work with members of Congress and the administration to remedy the situation.

Conclusion

Society must understand that supporting academic medicine ensures its vital role as an international leader in education, research and patient care. Medical schools and their faculties educate fully trained physicians to meet the nation's health care needs. Teaching hospitals provide an environment for the conduct of biomedical clinical research, serve as educational sites, and with their staff, work with academic physicians to deliver sophisticated patient care to all who need it. But academic institutions also need support to maintain their essential role in the health care system.

The AAMC is pleased that the HSA recognizes the important functions of these institutions. However, we must give considerable thought and attention to ensuring that these proposed changes, if enacted, would be implemented effectively and financed adequately. While we have some concerns about the two proposals, the AAMC shares in their overall objectives. We look forward to working with this subcommittee and the administration to ensure the future of academic medicine and the nation's health care system. We can afford to do no less.

TABLE 3
NUMBER OF RESIDENTS AND FELLOWS
RANKED BY TOTAL TRAINEES BY SPECIALTY
1993

Specialty	No. of Residents	No. of Fellows	No. Physician in GME	% of Total	Cumulative %
Internal Medicine	19,962	10,581	30,543	30.9%	30.9%
Pediatrics	6,600	2,389	8,989	9.1%	40.0%
Surgery	7,832	886	8,718	8.8%	48.8%
Family Practice	6,925	539	7,464	7.6%	56.4%
Psychiatry	5,138	912	6,050	6.1%	62.5%
Anesthesiology	5,078	896	5,974	6.0%	68.6%
Obstetrics-Gynecology	4,665	620	5,285	5.3%	73.9%
Radiology	3,606	1,478	5,084	5.1%	79.0%
Orthopedic Surgery	2,752	583	3,335	3.4%	82.4%
Pathology	2,222	734	2,956	3.0%	85.4%
Emergency Medicine	2,024	354	2,378	2.4%	87.8%
Ophthalmology	1,476	332	1,808	1.8%	89.6%
Neurology	1,355	444	1,799	1.8%	91.5%
Transitional	1,589	--	1,589	1.6%	93.1%
Otolaryngology	819	403	1,222	1.2%	94.3%
Urology	911	246	1,157	1.2%	95.5%
Physical Medicine/Rehab.	993	118	1,111	1.1%	96.6%
Dermatology	708	261	969	1.0%	97.6%
Neurosurgery	630	224	854	0.9%	98.5%
Plastic Surgery	161	362	523	0.5%	99.0%
Thoracic Surgery	--	345	345	0.3%	99.3%
Preventive Medicine	235	57	292	0.3%	99.6%
Allergy/Immunology	--	169	169	0.2%	99.8%
Nuclear Medicine	90	45	135	0.1%	99.9%
Colon & Rectal Surgery	--	64	64	0.1%	100.0%
TOTAL	75,771	23,042	98,813	100.0%	

Source: Association of American Medical Colleges, Medical Education Census, SAIMS Database, 1993

TABLE 4
NUMBER OF FMGs IN GME
RANKED BY PERCENTAGE OF FMGs OF TOTAL TRAINEES BY SPECIALTY
1993

Specialty	No. of FMGs	No. Physician in GME	% of Total	% of Total FMGs
Nuclear Medicine	52	135	38.5%	0.2%
Internal Medicine	10,402	30,543	34.1%	49.8%
Pediatrics	2,787	8,989	31.0%	13.3%
Allergy/Immunology	52	169	30.8%	0.2%
Neurology	526	1,799	29.2%	2.5%
Pathology	819	2,956	27.7%	3.9%
Psychiatry	1,534	6,050	25.4%	7.3%
Family Practice	1,396	7,464	18.7%	6.7%
Transitional	293	1,589	18.4%	1.4%
Colon & Rectal Surgery	11	64	17.2%	0.1%
Anesthesiology	862	5,974	14.4%	4.1%
Preventive Medicine	36	292	12.3%	0.2%
Physical Medicine/Rehab.	110	1,111	9.9%	0.5%
Surgery	849	8,718	9.7%	4.1%
Neurosurgery	83	854	9.7%	0.4%
Thoracic Surgery	31	345	9.0%	0.1%
Plastic Surgery	37	523	7.1%	0.2%
Obstetrics-Gynecology	369	5,285	7.0%	1.8%
Ophthalmology	107	1,808	5.9%	0.5%
Radiology	269	5,084	5.3%	1.3%
Urology	59	1,157	5.1%	0.3%
Dermatology	43	969	4.4%	0.2%
Emergency Medicine	101	2,378	4.2%	0.5%
Otolaryngology	25	1,222	2.0%	0.1%
Orthopedic Surgery	49	3,335	1.5%	0.2%
TOTAL	20,902	98,813	21.2%	100.0%

Source: Association of American Medical Colleges, Medical Education Census, SAIMS Database, 1993

TABLE 5
PHYSICIANS IN GME RANKED BY STATE, 1993

State	No. Physician in GME	% of Total	Cumulative %
New York	14,805	15.0%	15.0%
California	9,004	9.1%	24.1%
Pennsylvania	7,236	7.3%	31.4%
Texas	5,859	5.9%	37.3%
Illinois	5,530	5.6%	42.9%
Ohio	4,728	4.8%	47.7%
Massachusetts	4,433	4.5%	52.2%
Michigan	3,904	4.0%	56.2%
New Jersey	2,603	2.6%	58.8%
Maryland	2,491	2.5%	61.3%
Florida	2,413	2.4%	63.8%
Missouri	2,233	2.3%	66.0%
North Carolina	2,211	2.2%	68.3%
Minnesota	2,193	2.2%	70.5%
District of Columbia	2,179	2.2%	72.7%
Connecticut	1,878	1.9%	74.6%
Georgia	1,826	1.8%	76.4%
Tennessee	1,798	1.8%	78.3%
Virginia	1,751	1.8%	80.0%
Wisconsin	1,583	1.6%	81.6%
Louisiana	1,504	1.5%	83.1%
Washington	1,415	1.4%	84.6%
Indiana	1,162	1.2%	85.8%
Colorado	1,130	1.1%	86.9%
Alabama	1,002	1.0%	87.9%
Arizona	997	1.0%	88.9%
Kentucky	986	1.0%	89.9%
South Carolina	908	0.9%	90.8%
Iowa	846	0.9%	91.7%
Puerto Rico	779	0.8%	92.5%
Kansas	702	0.7%	93.2%
Oklahoma	683	0.7%	93.9%
Oregon	648	0.7%	94.5%
Rhode Island	576	0.6%	95.1%
Utah	560	0.6%	95.7%
Arkansas	534	0.5%	96.2%
Nebraska	499	0.5%	96.7%
West Virginia	496	0.5%	97.2%
Mississippi	432	0.4%	97.7%
Hawaii	430	0.4%	98.1%
New Mexico	386	0.4%	98.5%
Vermont	265	0.3%	98.8%
New Hampshire	238	0.2%	99.0%
Maine	214	0.2%	99.2%
Delaware	195	0.2%	99.4%
North Dakota	120	0.1%	99.5%
Nevada	112	0.1%	99.7%
South Dakota	85	0.1%	99.7%
Idaho	39	0.0%	99.8%
Wyoming	38	0.0%	99.8%
Montana	0	0.0%	99.8%
Alaska	0	0.0%	99.8%
Unidentified Military	174	0.2%	100.0%
TOTAL	98,813	100.0%	

Source: Association of American Medical Colleges, Medical Education Census, SAIMS Database, 1993

TABLE 6
PHYSICIANS IN GME PER THOUSAND POPULATION BY STATE, 1993

State	No. Physicians in GME	Population	Phys. in GME per 1,000 population
District of Columbia	2,179	589,000	3.70
New York	14,805	18,119,000	0.82
Massachusetts	4,433	5,998,000	0.74
Pennsylvania	7,236	12,009,000	0.60
Rhode Island	576	1,005,000	0.57
Connecticut	1,878	3,281,000	0.57
Maryland	2,491	4,908,000	0.51
Minnesota	2,193	4,480,000	0.49
Illinois	5,530	11,631,000	0.48
Vermont	265	570,000	0.46
Missouri	2,233	5,193,000	0.43
Ohio	4,728	11,016,000	0.43
Michigan	3,904	9,437,000	0.41
Hawaii	430	1,160,000	0.37
Tennessee	1,798	5,024,000	0.36
Louisiana	1,504	4,287,000	0.35
New Jersey	2,603	7,789,000	0.33
Texas	5,859	17,656,000	0.33
Colorado	1,130	3,470,000	0.33
North Carolina	2,211	6,843,000	0.32
Wisconsin	1,583	5,007,000	0.32
Nebraska	499	1,606,000	0.31
Utah	560	1,813,000	0.31
Iowa	846	2,812,000	0.30
California	9,004	30,867,000	0.29
Delaware	195	689,000	0.28
Kansas	702	2,523,000	0.28
Washington	1,415	5,136,000	0.28
Virginia	1,751	6,377,000	0.27
West Virginia	496	1,812,000	0.27
Georgia	1,826	6,751,000	0.27
Kentucky	986	3,755,000	0.26
Arizona	997	3,832,000	0.26
South Carolina	908	3,603,000	0.25
New Mexico	386	1,581,000	0.24
Alabama	1,002	4,136,000	0.24
Arkansas	534	2,399,000	0.22
Oregon	648	2,977,000	0.22
New Hampshire	238	1,111,000	0.21
Oklahoma	683	3,212,000	0.21
Indiana	1,162	5,662,000	0.21
North Dakota	120	636,000	0.19
Florida	2,413	13,488,000	0.18
Maine	214	1,235,000	0.17
Mississippi	432	2,614,000	0.17
South Dakota	85	711,000	0.12
Nevada	112	1,327,000	0.08
Wyoming	38	466,000	0.08
Idaho	39	1,067,000	0.04
Montana	0	824,000	0
Alaska	0	568,000	0
Puerto Rico	779	—	—
Unidentified Military	174	—	—
TOTAL	98,813	255,062,000	0.39

Source: Association of American Medical Colleges, Medical Education Census, SAIMS Database, 1993
Population Data: U.S. Bureau of the Census, Current Population Reports, 1992

TABLE 7
FMGs IN GME, RANKED BY % OF PHYSICIANS IN GME BY STATE, 1993

State	No. Physicians in GME	No. of FMGs	% FMGs of	% of Total FMGs in U.S.
New Jersey	2,603	1,377	52.9%	6.6%
North Dakota	120	50	41.7%	0.2%
New York	14,805	6,168	41.7%	29.5%
Nevada	112	40	35.7%	0.2%
Puerto Rico	779	269	34.5%	1.3%
Illinois	5,530	1,797	32.5%	8.6%
Michigan	3,904	1,154	29.6%	5.5%
Connecticut	1,878	549	29.2%	2.6%
West Virginia	496	121	24.4%	0.6%
Rhode Island	576	123	21.4%	0.6%
Pennsylvania	7,236	1,419	19.6%	6.8%
Wisconsin	1,583	306	19.3%	1.5%
Maryland	2,491	479	19.2%	2.3%
Ohio	4,728	908	19.2%	4.3%
District of Columbia	2,179	411	18.9%	2.0%
Florida	2,413	417	17.3%	2.0%
Missouri	2,233	367	16.4%	1.8%
Massachusetts	4,433	722	16.3%	3.5%
Oklahoma	683	107	15.7%	0.5%
Tennessee	1,798	275	15.3%	1.3%
Minnesota	2,193	323	14.7%	1.5%
Texas	5,859	845	14.4%	4.0%
South Dakota	85	11	12.9%	0.1%
Georgia	1,826	222	12.2%	1.1%
Indiana	1,162	139	12.0%	0.7%
Kentucky	986	113	11.5%	0.5%
Virginia	1,751	185	10.6%	0.9%
California	9,004	943	10.5%	4.5%
Iowa	846	81	9.6%	0.4%
Vermont	265	25	9.4%	0.1%
Nebraska	499	47	9.4%	0.2%
Maine	214	20	9.3%	0.1%
Delaware	195	18	9.2%	0.1%
Alabama	1,002	91	9.1%	0.4%
Kansas	702	63	9.0%	0.3%
Arkansas	534	45	8.4%	0.2%
Arizona	997	77	7.7%	0.4%
Hawaii	430	33	7.7%	0.2%
Mississippi	432	31	7.2%	0.1%
South Carolina	908	63	6.9%	0.3%
North Carolina	2,211	152	6.9%	0.7%
Louisiana	1,504	95	6.3%	0.5%
Utah	560	32	5.7%	0.2%
New Mexico	386	20	5.2%	0.1%
Idaho	39	2	5.1%	0.0%
Colorado	1,130	57	5.0%	0.3%
New Hampshire	238	12	5.0%	0.1%
Oregon	648	30	4.6%	0.1%
Washington	1,415	65	4.6%	0.3%
Wyoming	38	1	2.6%	0.0%
Montana	0	0	--	
Alaska	0	0	--	
Unidentified Military	174	2	1.1%	0.0%
TOTAL	98,813	20,902	21.2%	100.0%

Source: Association of American Medical Colleges, Medical Education Census, SAIMS Database, 1993



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GOALS AND PRINCIPLES FOR HEALTH CARE REFORM

The Association of American Medical Colleges proposes and advocates the following goals and supporting principles for health care reform in the 1990s:

Any health care system must strive to achieve five goals: (1) giving all Americans the chance for a healthy life; (2) providing universal access to health care; (3) recognizing that once health care excellence is achieved, the necessary resources must be provided so that quality and capacity are maintained; (4) instituting cost containment measures that do not compromise the quality of health care; and (5) supporting the essential roles of medical and other health care professional education and of biomedical, behavioral, and health services research.

- Any health care reform plan must include not only diagnosis and treatment for existing illness, but also health-promotion and disease-prevention efforts so that each American has the opportunity for a healthy life.
- Health insurance must be transportable, affordable, and continuous.
- Any health care reform plan must guarantee access to a specified set of basic services, including preventive care.
- Even in a system that guarantees universal access, some individuals may lack health insurance, either by choice or by circumstances beyond their control. To eliminate the possibility that some individuals would choose not to participate in an available health insurance program, the health care system should be designed to require eligible individuals to participate. For those individuals who lack insurance because of circumstances beyond their control, alternative mechanisms to assure payment for the services they use must be maintained and funded.

- Existing public and government programs serving defined populations should not be terminated or significantly changed unless an alternative system has the ability to adequately replace them.
- Efficient, effective, and comprehensive health care must be of consistent high quality. The criteria for assessing these factors should be continually re-evaluated and updated through the results of research efforts.
- In areas where the current infrastructure is inadequate to meet the needs of underserved and disadvantaged populations, the health care delivery system must be improved and expanded to assure high-quality care and support systems.
- Reforms should be phased in over a reasonable time frame that allows the health care system adequate time to adapt to the demands of expanded coverage while ensuring that high quality care continues to be delivered.
- Appropriate cost control mechanisms must be incorporated into the health care system without creating barriers to expanding access and promoting quality and should reflect broader societal objectives and economic needs.
- Cost containment efforts should: (1) ensure efficient and effective health care delivery; (2) not become an impediment to individuals seeking care; and (3) not place an unreasonable financial burden on the providers of care.
- The health care financing system should recognize and support the additional costs that are incurred by those institutions that accept responsibility for the essential activities of medical and health care professional education, health-related research, and technology development.

ACADEMIC MEDICINE: THE CORNERSTONE OF THE AMERICAN HEALTH CARE SYSTEM

Medical schools, teaching hospitals, and their faculty members and staff are valuable resources that serve national as well as local and regional health care needs. Their education, research, and patient care activities are the cornerstone on which the American health care system is built.

These academic institutions house much of the nation's biomedical, behavioral, and health-related research; and teaching hospitals make available treatments that may be unavailable elsewhere, provide the highest quality care, and are places of last resort for many who need care but do not have the wherewithal to pay for it.

The restructuring of the national economy underway as part of the president's economic plan, when combined with changes that are part of the health care reform proposal, may have serious and unintended consequences for academic medicine, which is the cornerstone of the American health care system.

Change will be counterproductive if reforms in the health care system do not protect and strengthen all of the essential elements of our system:

- Education of excellently prepared physicians and other health care workers;
- Medical research producing scientific advances that translate into prevention of disease and the cure or alleviation of human suffering; and
- Innovation, evaluation, and development of new treatments and procedures that have made American medical care the best in the world.

Medical schools and teaching hospitals have unique and valuable roles in the nation's health care system. Their contributions depend on multiple sources of financing, each of which is increasingly constrained. This simultaneous challenge to all sources of support jeopardizes the ability of medical schools and teaching hospitals to meet their societal commitments.

If health care reform constrains the flexibility that has existed within the patient care payment system to support academic medicine's other missions, then the reformed health care system must make explicit provision for new and dedicated funding mechanisms for these missions. Support must be provided to allow academic medicine to continue:

- Educating the world's best physicians and assuring that the physicians in training, as well as those now in practice, are prepared for the nation's evolving health care needs;
- Conducting research that will determine the most cost-effective and efficacious of present therapies, thus arming future physicians with the tools to reduce human suffering and lower the costs of health care even further;
- Providing much needed specialized services such as trauma care, burn units, and transplantation centers; and
- Caring for those who remain uninsured during a transition period to universal coverage or for those who may never be adequately incorporated into the health system.

The synergism between research and education, especially biomedical research and medical education, is readily apparent: medical school curricula depend heavily on biomedical research findings, and medical school faculty typically conduct such research in addition to teaching. Until recently, the link between traditional health services research and medical education has been less apparent for two reasons: traditional health services research was perceived as less relevant, and the research projects were smaller and often located in schools of public health and other health professions schools rather than medical schools. The relevance of health services research to medical education is increasing with the growth of outcomes research and an increased awareness of medical students' and residents' need to understand the health care delivery system.

SUPPORT FOR BIOMEDICAL, BEHAVIORAL, AND HEALTH SERVICES RESEARCH

- The vitality and success of the U.S. health care system has depended, and will continue to depend, upon the ongoing generation of new basic biomedical and behavioral information. The federal government and other organizations must maintain their respective investments in a balanced and stable program of support for the acquisition of new basic knowledge and clinical applications that will improve the effectiveness of the health care system. The quality of this endeavor can only be ensured through continued reliance upon an effective peer-review system for the allocation of resources targeted to biomedical and behavioral research. Such funds must not be commingled with funding for other purposes.
- Appropriate public and private organizations, including the Association of American Medical Colleges, should consider the evolving requirements and implications of health care reform initiatives in developing future policy positions on biomedical and behavioral research that assure a responsive and vigorous research enterprise.
- Initiatives for health care reform should increase the funding and sponsorship of peer-reviewed health services research because of its importance to overall reform strategies. While a variety of funding sources are possible, funding for health services research should be separate from funding for biomedical research.
- Organizations such as the Association for Health Services Research, the Institute of Medicine, and/or other appropriate organizations should convene public and other private organizations concerned about health services research to: (1) develop a clearinghouse for health services research projects and findings; (2) propose appropriate expansion of funding for outcomes and other health services research; and (3) recommend a time period during which the increased resources, including manpower and funding, should be phased in.

As is true of our current health care system, whatever reformed system may be adopted will strive to provide health care that is beneficial in terms of both outcome and cost. It is through health-related research -- biomedical,

behavioral, and health services -- that advances in diagnosis and treatment are discovered, evaluated, and, finally, made available to those who need them. Only by ensuring adequate and stable funding for all types of health-related research will it be possible to provide Americans with the most appropriate and effective care available.

GRADUATE MEDICAL EDUCATION

- To encourage medical students to choose careers that meet national physician supply goals, incentive programs aimed at individuals throughout the medical education and practice continuum should be created and/or maintained. Individuals' behavior in choosing certain careers is influenced best by offering sets of incentives that affect them directly and personally as medical students, resident trainees, and practicing physicians.
- Because graduate medical education is an integral component of educating physicians to provide all Americans with high-quality and cost-effective health care, it should continue to receive broad-based societal support. All public and private payers of health care services should be required to contribute to a national fund separate from payments for patient care services, to finance graduate medical education.
- To assure that the financial support for graduate medical education is used to promote and improve the nation's health, a National Physician Resources Commission (NPRC) should be established. The NPRC would be an independent body, recognized by the federal government, with broad representation from the health care sector and other relevant societal groups. The NPRC would be responsible for:
 - * projecting the aggregate supply of physicians needed to support the nation's health care delivery system;
 - * setting national goals for both the total number of graduate medical education positions and for the appropriate mix of residency positions that would be dedicated to the education of generalist and other specialist physicians;

- * reviewing the availability and appropriateness of incentive systems to assure that they reinforce national goals; and
- * providing a linkage between the work force planning activities for physicians and other health professions.
- Upon the establishment of an all-payer national fund and a determination that significant progress is not occurring in achieving the appropriate specialty redistribution, the NPRC could assume responsibility for authorizing payment for graduate medical education costs. The NPRC also could establish guidelines for the circumstances under which other funding could be used for graduate medical education activity.

In addition, the national commission could assist in the optional development of decentralized planning bodies for the physician work force to assure that regional, state, and local needs, objectives, and characteristics are recognized. Functioning under the auspices of the NPRC, these independent bodies would have broad public and private representation from the health care sector and other communities. The scope and role of these bodies would be determined by the NPRC.

- Medical schools, teaching hospitals, and other organizations currently -- and potentially -- involved in graduate medical education should strongly consider the creation of formal associations, or "graduate medical consortia." Such consortia could provide enhanced mechanisms to assure the continuity of medical education and to develop centralized support, direction, and coordination for member institutions so that they function collectively to meet changing work force requirements.
- The Accreditation Council for Graduate Medical Education (ACGME) or the American Osteopathic Association's (AOA) Committee on Post-doctoral Training should continue to accredit programs solely on the basis of whether the programs meet established educational criteria. The accreditation process should remain separate from physician work force planning, allocation, and financing activity.
- The level of payments for graduate medical education should recognize all costs, including residents' stipends and benefits, salaries and benefits

related to faculty supervision, allocated overhead, and costs related to the infra-structure overhead inherent in the graduate medical education process. The payments should be made to the organization or entity that incurs these costs.

- Transitional relief funds should be made available to teaching hospitals that lose residency positions as part of the fundamental changes that may occur in the structure and financing of graduate medical education. Changes in the number and specialty mix of residents and their sites of training would be disruptive to teaching hospitals and their service activities and could have a particularly profound impact on some institutions. In these cases, relief funds would mitigate the effects of graduate medical education reform.
- Because of its public role and responsibilities, the Medicare program should continue to recognize and support the costs of graduate medical education. In addition, the special and unique patient care costs of teaching institutions should continue to be recognized and paid through the indirect medical education (IME) adjustment in the Medicare prospective payment system. As changes are made in the overall health care delivery system and within the Medicare program, it may be appropriate to re-examine the purpose and level of Medicare payment mechanisms. Until such changes and/or alternative payment mechanisms have been developed, however, the payment structure and level of funding provided by the Medicare program for graduate medical education costs and the special costs of teaching hospitals should remain unchanged.

STATEMENT OF ROGER J. BULGER

Mr. WAXMAN. Dr. Bulger.

Mr. BULGER. Mr. Chairman, thank you very much. The Association of Academic Health Centers represents the leadership of more than 100 of the Nation's academic health centers, institutions that have a multi-health professional perspective because they include, at a minimum, a school of osteopathic or allopathic medicine, at least one other health professional school or program, and one or more affiliated teaching hospitals.

We have been on record for several years supporting comprehensive systemic health care reform and believe that the President's plan meets these criteria.

The AHC appreciates this subcommittee's longstanding commitment to health care programs and we are pleased that both the President's Health Security Act and the Waxman-Rockefeller Primary Care Workforce Act takes special note of the educational responsibilities of our institutions by virtue of the earmarked educational funding for direct and indirect costs.

We recognize that the purpose of these funds is to allow us to implement the work force policy objectives of the legislation. Our statement for the record presents our position on a number of these policy objectives and is based on a detailed survey of our members.

In summary, the large majority of our members and of our board of directors are supportive of the following: (1) a national council for physician specialty training programs; (2) greater emphasis on primary care; (3) all payer funding for education; (4) enhanced funding for the Public Health Service initiatives; (5) an expanded program to enhance quality; and (6) enhanced strategies to provide adequate patient access to care in underserved areas.

Both the Health Security Act and the Waxman/Rockefeller bill recognize that universal insurance coverage opens the way for but does not automatically translate into universal access to health care for all of our citizens.

Today I want to focus on three major points that are of paramount concern for academic health centers. First, we must point out the critical need to finish the job really already ongoing of health care reform by passing a bill guaranteeing universal coverage for all of our citizens.

The President and the Congress expressing their commitment to health care reform have already unleashed the forces of managed care throughout the Nation. This tide will not be stemmed with or without Federal legislation.

America's major teaching hospitals, which account for 6 percent of the beds, currently provide almost 30 percent of the Nation's uncompensated care. Up to now, they have been able to cover these losses with income from other patient care sources. The managed care sweep is making such cross subsidization from those who can pay to those who can't increasingly unrealistic and inappropriate.

Without a program for universal health care coverage, our teaching hospitals will experience an even greater uncompensated care burden, having already been stripped of their capacity to cover such losses. This is a worst case scenario for academic health centers that might spell disaster for or closure of some of our most important research institutions.

Second, the establishment of a new workforce policy is not enough to insure effective implementation. We recommend that the funding mechanisms be designed so that the educational dollars follow the student to the site of care and training.

In order to meet the twin policy objectives of more primary care professionals and more training at ambulatory sites, we recommend that funding streams be directed from the government to the institution, such that the educational administrators, rather than service administrators, be held accountable for the adequate funding of the teaching sites.

Third, we recommend that the provisions for community practice networks and health plans in the Health Security Act be altered so as to encourage partnerships involving existing providers and academic health centers. These partnerships should aim at establishing an organized delivery system or accountable health plan to serve a discrete, geographically identifiable chronically underserved rural or urban area, the development of an organizationally effective network or Federally qualified health centers, other providers in those communities, an expanded National Health Service Corps, and academic health centers is crucial if we hope to meet the Nation's interrelated needs for access to quality care, community based primary care training, and continuing education and support for practitioners in those areas.

Mr. Chairman, I thank you for this opportunity to testify and will be very happy to answer any questions.

Mr. WAXMAN. Thank you very much, Dr. Bulger.

[Testimony resumes on p. 445.]

[The prepared statement of Mr. Bulger follows:]

STATEMENT OF ROGER J. BULGER

Mr. Chairman and members of the committee, I am Roger J. Bulger, M.D., President of the Association of Academic Health Centers (AHC). The AHC represents the leadership of more than one 100 of the nation's major academic health centers: institutions that include, at a minimum, a school of allopathic or osteopathic medicine, at least one other health professions school or program, and one or more affiliated teaching hospitals. We appreciate the subcommittee's efforts of many years to improve the nation's health care services, research, and education, and are pleased to comment on key health care workforce and access provisions in the President's Health Security Act and the Waxman/Rockefeller Primary Care Workforce Act.

The mission of academic health centers combines research, education, and patient care. These centers are the nation's primary resources for health professions education and research, and provide a substantial amount of health services, including more than 20 percent of the nation's uncompensated care.

The AHC has a long-standing commitment to health reform -- and recognizes that fundamental changes are needed on the part of academic health centers as part of that reform effort. We articulated basic principles for health care reform five years ago. In November, 1993, the AHC reaffirmed those principles which call for universal access to health care with particular attention to the needs of the traditionally underserved, systemic reform of the health care system, quality of care, financing mechanisms with built-in devices to achieve cost control while protecting education and innovation, the development of federal policies to promote

health and prevent disease, and major reform of the medical liability process.

The AHC is pleased that these principles are largely reflected in President Clinton's health care reform plan. The AHC is committed to working with the Administration and the Congress in translating the principles to an operational plan.

Further, the AHC has translated the principles into specific public policy positions on key legislative policy issues in the Health Security Act and the Waxman/Rockefeller bill that are of particular interest to academic health centers. The Association will continue to refine these positions as the health care reform debate proceeds.

Universal Coverage

Health care reform must include universal coverage and access to care. While we recognize that many tradeoffs are entailed in developing and implementing a reform plan, universal coverage cannot be set aside.

And, it is vitally important to recognize that insurance coverage alone will not address the health care needs of large segments of the population. The Association proposes an innovative new partnership between institutions responsible for training the next generation of health care providers and the developing networks of front-line providers of community health care services in medically underserved rural and urban areas. That proposal is presented in greater detail later in this statement.

Definition of Academic Health Centers

The term "academic health center" should be defined in legislation as an entity that includes at a minimum:

- o an allopathic or osteopathic school of medicine; and
- o one or more other health professional schools or programs; and
- o one or more affiliated teaching hospitals.

Health Professions Education

Overall

The workforce produced by the health professions education system is the keystone to the success of health care reform. Funding must guarantee appropriate support for the institutions that educate health care professionals to meet this need and ensure an adequate supply of health professions educators and clinician scientists, and the full array of health professionals to meet the nation's health care needs.

Medical education

While the health care reform debate has focused extensively on graduate medical education, future issues in the clinical education of medical students during their four years of medical school must also be addressed. The clinical education of medical students requires that they interact with patients in a variety of supervised health care settings. This activity generates direct and indirect costs that have traditionally been largely borne by professional and institutional clinical service revenues. Under

health care reform, these revenues will be sharply reduced, while at the same time clinical education will need to be shifted to new sites outside the teaching hospital.

The AHC believes that these clinical medical education issues must be put on the agenda. New and adequate funding mechanisms for meeting these educational costs must be identified.

Physician specialty training

The AHC supports a shift to a better balance among primary care and specialty physicians. Further, we urge policymakers to recognize a broader, multidisciplinary approach to primary care: the delivery by a broad range of health professionals of primary care services compatible with their professional education and training.

While marketplace pressures are likely to lead to shifts in the specialty distribution as well as in the overall supply of physicians, the AHC believes that at this time a national framework is appropriate under which workforce policy is defined and supported with specific funding streams in order to meet the health care workforce needs of the nation.

Therefore, the AHC supports the creation of a national council to establish and implement policy with regard to physician specialty training programs and to encourage the development and coordination of workforce policies across the health professions.

Criteria for Action: Such a council should be required to follow certain criteria in setting and implementing policy.

- o First, it should be required to consider the evolving market for health care -- a market that is already

changing its demands on the health professions education system.

- o Second, it should develop its recommendations in consultation with the expert advice of medical and other health professional specialty organizations, and the relevant residency review boards and the Bureau of Professional Education of the American Osteopathic Association.
- o Finally, the council should reassess its policies and responsibilities every three years in light of changing needs and circumstances. Given the situation we face today, a council is appropriate. But its policies and priorities, and even its existence, should be reassessed in the future to assure that the Council does not outlive its usefulness.

Scope: While its most visible immediate focus will be on determining the number of residency positions, the council's scope of activity should include a broad view of the health care workforce, addressing physician residencies in light of the need and supply of other health professionals.

Composition: The membership of the council should be constituted in a manner that reflects its multi-professional scope and responsibilities.

Independence: The council should be as independent from the political process as possible.

Residency training positions: The council should determine the number of authorized physician residency positions in the United States, and should allocate those positions to residency training programs. This should extend beyond graduate medical education to include programs in osteopathic medicine, dentistry, and podiatry that Medicare has traditionally supported through its indirect medical education payment adjuster.

Primary care allocations: As noted above, the AHC supports as a matter of policy a shift to a better balance among primary care and specialty physicians. Given the imperative to make this change, the council can be assigned an appropriate physician primary care target percentage such as 50 percent (assuming that primary care is defined as family practice, general internal medicine, general pediatrics, and obstetrics-gynecology). However, the dynamic changes in society's health care needs dictate that this number not be locked-in forever. The council should be empowered to reassess and revise this target in the future.

Timing: The timetable for implementing the allocations of residencies by the national council must balance the need for change with the realities of implementation. While recommendations could begin to be phased-in at the end of the 1990s, full implementation cannot reasonably be expected until academic year 2000-01.

Funding and Implementation

Establishing new policies is not enough: we recommend that you provide the funding in a manner designed to allow educational institutions to allocate the funds to the extent practical so that those entities can effectively implement the changes required -- more primary care professionals, and more training at ambulatory sites. Academic health centers are prepared to make the changes necessary to redirect health professions education to meet the needs of the population under health care reform, but the funding

mechanism must reinforce the policy in order to allow us to accomplish the workforce objectives in the legislation.

Funding for direct and indirect costs

The costs of clinical medical education (direct and indirect) must be identified and funded through separate, earmarked funding streams financed by all payers. Funding should guarantee that payment attains appropriate levels in order to achieve the stated objectives of reform.

Direct costs: Direct educational costs should be paid to the highest academic officer of the education program involved. That individual, in turn, would be responsible for reallocation of the funds among the educational programs.

The AHC believes that this funding mechanism is important to ensure that the educational institution involved has the incentives, capacity, and accountability for implementing the changes required under reform -- more primary care professionals, and more training at ambulatory care sites.

This funding mechanism should be extended to all health professional training programs that Medicare currently recognizes in paying the direct costs of education (medicine, osteopathy, dentistry, podiatry, nursing, allied health).

Indirect costs: Indirect costs (the higher operational costs for entities that provide education as part of the service delivery system) should be paid directly to the service settings, both inpatient and outpatient, that incur these higher costs. However, they should be paid only to settings approved as educational sites

by the highest academic officer of the educational institution involved. While the dollars would flow directly to the teaching hospital or physician practice or clinic, the highest academic officer should, at a minimum, be in a position to approve sites for education in order to reinforce the incentives for implementing the new workforce policies, and to give the educational entities involved more capacity to implement the educational changes required.

This funding mechanism should be used for the physician training programs that Medicare currently recognizes in computing and paying indirect costs (i.e., medicine, osteopathy, dentistry, podiatry).

Quality Assessment and Assurance

Academic health centers are the nation's centers for lifelong learning for the full range of health professionals -- a process that is vital for any quality assurance system. The AHC believes that effective quality assurance programs should assign a central role to academic centers as the resources that can best offer the professional education and research required for continuous quality improvement and lifetime learning.

In addition, adequate funding should be available to establish quality assessment data systems to ensure continuing feedback to health professionals as part of the lifelong learning in order to continuously improve the quality of care.

Patient Access to Academic Health Centers

Health care financing entities such as health alliances should require that all health plans contract with academic health centers in order to assure that patients have access to these institutions.

These contracts should include the specialized treatments and expertise unique to academic health centers. The definition of these services, as well as the specific contracting requirements, must be developed. In addition to the specialized treatment services, it should be clear that nothing precludes health plans from contracting with academic health centers for the full range of services provided by those institutions.

Public Health Service Initiatives

Overall approach/funding

A wide range of Public Health Service Act initiatives is essential to provide the infrastructure of health care services and knowledge to the diverse populations and regions of the country. The AHC is concerned if funding for these initiatives -- unlike all of the other funding in health reform -- is in the form of traditional authorizations of appropriations, because it is clear that those authorizations will have to be shortchanged in the appropriations process due to the budget caps imposed on the appropriations committees. The result will be a continuation of the problem in which the public health infrastructure is underfunded.

Funding for Public Health Service programs under health care reform should be in addition to current base funding levels and should be financed through a dedicated financing mechanism that reflects a portion of the total health care premiums and/or an earmarked public source.

Priority programs

Especially high priority should be assigned in design of the Public Health Service initiatives to the following:

- o National Institutes of Health: research on Health Promotion and Disease Prevention.
- o Health services research: research on health care reform, appropriateness of care, quality and outcomes, clinical practice guidelines, information systems, and consumer choice.
- o Health care sites: expansion of support for programs of the Area Health Education Centers (AHECs), community health centers, and the National Health Service Corps.
- o Health workforce training: special programs for training primary care physicians, physician assistants, nurse practitioners, nurse midwives, and underrepresented minorities and disadvantaged persons.

Access initiative: new partnership between community health organizations and academic health centers

Both the Health Security Act and the Waxman/Rockefeller bill recognize that improved access -- especially in medically underserved communities -- requires more than just insurance coverage. We strongly support that conclusion. For five years, the Association of Academic Health Centers has convened a task force on human resources for health -- a task force that has reviewed and made recommendations on many of the issues under consideration in the subcommittee and the Congress today. We

support enhanced access for underserved populations through programs such as enhanced funding for federally qualified health centers and the National Health Service Corps.

And, we support the provisions in the Health Security Act for developing community practice networks and community health plans in underserved areas. Further, we recommend as a high priority that this initiative be improved by ensuring that linkages be developed between academic health centers and those networks of federally qualified health centers and other providers in the underserved communities.

These linkages can help achieve some of the multiple objectives of reform -- objectives that today are missed when initiatives to improve access are not coupled with efforts to redirect medical education. A new partnership between academic health centers and community health providers would enhance access to service and provide for community-based training. Enhanced telecommunications systems would allow community-based providers to take advantage of new technologies to enhance education and service. And such a partnership can provide the continuing education and lifetime learning that are necessary to continuously improve the quality of care.

This support and linkage to a broader professional and academic community can help traditionally underserved and isolated communities retain providers rather than having to constantly recruit new ones, as well as ensure a viable, long-term professional practice.

Mr. Chairman, the Association appreciates this opportunity to testify. We would be pleased to work with the subcommittee members and staff as you develop your health care reform proposals.

MR. WAXMAN. Dr. Budetti.

STATEMENT OF PETER P. BUDETTI

Mr. BUDETTI. Thank you, Mr. Chairman. It is a great pleasure to be on this side of the table here with you this afternoon.

I believe that there are four points that need to be emphasized when we are talking about what to do with respect to trying to improve the situation for primary care, and I would like to just touch on those four points briefly this afternoon.

First of all, I believe that the need is great for Federal initiatives because it is—they are necessary to counteract some of the counterproductive effects of existing Federal health policies.

Second, I think that the likelihood that the marketplace will do this on its own is very low and I think that Federal action is necessary precisely because the marketplace will not accomplish this task.

Third, I think that concerns about the way that the government would go about it, while I think genuine, are not necessary. I think that the process could be done in a way that was not necessarily heavy handed or highly inefficient.

And fourth, I am very concerned that failure to enact some of these changes would itself jeopardize the reform of the health care delivery system. Let me just touch on each one of those points briefly.

A number of Federal policies that were intended for other purposes have, in fact, had the unfortunate side effect of creating a climate that is not hospitable to the production of an adequate number of primary care practitioners, and in particular the policy that I think has created the problem to the most serious extent is the way that Medicare has been paying for graduate medical education over the years and how that interacts with the way that Medicare has been paying hospitals and teaching hospitals in particular, and while the Medicare GME payments, the graduate medical education payments are nominally neutral with respect to their effect on what residencies people go into, in fact, they make it extremely profitable for teaching hospitals to specialize and to have large numbers of house staff, unnecessarily large, I believe, members of house staff in the specialties that generate the highest revenues, and I believe that that has been a problem that has really skewed the ability of teaching hospitals to move in the direction of primary care.

Closely related to this is the fact that the money goes only for training programs that are based in the teaching hospitals and that is entirely inappropriate for the experiences that people need to develop into sophisticated primary care practitioners, and the money needs to flow to the teaching sites where adequate primary care training can take place.

Closely related to this is the problem that because of the focus of medical education in recent years and biomedical research, that I think that medical students have become indoctrinated into the idea that primary care is not a sophisticated or intellectually challenging activity, and I think we heard many of those remarks embodied in some of the discussion this morning with reference to the idea that only specialty care is good care, and that is a premise

that needs to be seriously challenged and that the amount of work that can be done, the amount of research that can be done and the intellectual stimulation of dealing with chronic, every day problems of our populous is very important.

Each of those Federal policies needs to be modified. If they are left in place, they will continue to mean that public dollars are going to support a development of a large number of specialist physicians in areas that are not good for the health care delivery system and are adding greatly to the costs of health care in this country.

Second, with respect to the marketplace, Dr. Bondurant referred to recent developments. It is absolutely true that a number of large HMO's have experienced what they perceive as shortages in the ability of primary care trainees to hire and they have engaged in aggressive recruiting programs and so forth to try to get primary care practitioners.

Large health care delivery systems are actually going out and buying up primary care practices, an unheard of development just a few years ago, but nevertheless, I think that that is too optimistic to think that those developments imply that the market is shifting so radically that there is no need for intervention.

In fact, the real decision making in terms of how many programs there are and what specialties are in the hands of the program administrators and the hospital administrators, and they do not respond to the same kinds of market forces. Even if the market were to work in the meantime, we would be producing vast numbers of additional unneeded trainees in the medical specialties and procedural specialties that would be that much more difficult to try to deal with in the future.

Third, I think that the time for study and analysis of this has long since passed. It has been two decades since the Federal Government really got involved in this with GMENAC and I think that their report, which is now about 15 years old, really summarizes what the problem was. It predicted the kinds of problems we are having right now.

Finally, Mr. Chairman, my last words are I think that if we continue to produce with public funds more and more highly specialized physicians, that they themselves will continue to have the incentive to stand as an obstacle to health care reform, and I think that is not something that needs to be supported with public dollars.

Thank you, very much and I will be delighted to respond to any questions.

[The prepared statement of Mr. Budetti follows:]

STATEMENT OF PETER P. BUDETTI

Mr. Chairman, Members of the Subcommittee. As someone who has spent many years deeply involved in this issue, I very much appreciate the opportunity to discuss my personal thoughts on the restructuring of our health professional workforce with you. Because I recognize well your time constraints, I ask that my full written statement be included in the Record of this hearing, and I will make only a few particular comments here today.

Mr. Chairman, I believe that four main points should be emphasized with respect to the need for federal action in shaping the future supply and distribution of health professionals. First, new federal initiatives are needed to reverse the counterproductive effects of certain existing federal policies. Second, federal action is needed to assure that we have an appropriate health care workforce in the future -- neither the current market forces nor foreseeable changes in the health care market will produce the mix of practitioners necessary to serve patient care needs. Third, federal action will be effective and need not be overly intrusive or heavy-handed. Fourth, health care reform itself would be jeopardized by failing to reform the workforce.

First, new federal initiatives are needed to reverse the counterproductive effects of certain existing federal policies. A number of federal policies designed for other quite legitimate purposes have had the unintended and unfortunate effect of creating a climate in medical education that is not hospitable to the production of an adequate number of primary care practitioners. These policies include: generous funding for Graduate Medical Education (GME) through Medicare and, in some states, Medicaid; Medicare's payment policies for hospital and physician services; and, support for a vast expansion of biomedical research in academic health centers and teaching hospitals.

Although nominally neutral on the distribution of residents among specialties, Medicare's GME payments in reality strongly encourage non-primary care physician specialization. They do so in part because they focus nearly exclusively on hospital-based training, cutting off the development of training sites needed for primary care experiences. Training in teaching hospitals is focused on severely ill patients receiving the latest in high-technology medical care. While such experiences are critically necessary for a broad, modern medical education, they are not appropriate for learning the skills and developing the practice style necessary to practice sophisticated primary care.

In addition, Medicare pays for graduate medical education at a level and in ways that create incentives for hospitals to train large number of physicians in highly specialized fields. Medicare's hospital- and physician-payment policies work hand-in-hand with the way that GME payments are made to encourage hospitals to emphasize non-primary care specialties. Under Medicare's hospital-payment policies, specialist residents and fellows help generate far greater patient-care revenues than do primary care residents. This not only encourages teaching hospitals to favor specialties that treat the most profitable DRGs, but also provides

a highly lucrative bonus by multiplying the DRG payments more and more as hospitals add residents.

Finally, the emphasis on biomedical research has produced a generation of students who have rarely seen primary care researchers, particularly not ones in positions of stature. Instead, these students have been impressed by the complexities, stature, and potential funding for biomedical research, and as a result think that primary care concerns such as treating chronic conditions among the elderly or common low-back pain are less intellectually challenging and less important than life-or-death problems such as heart disease and cancer.

Each of these existing federal policies needs to be modified or counterbalanced if the educational setting is to encourage primary care. Failing to change these federal policies is not a neutral position; such failure is an action that will continue to use federal dollars to subsidize and encourage ever greater specialization.

This Subcommittee has addressed these issues in the past, and now has the opportunity to include comprehensive measures in health reform. In particular, a complete revision of the approach to paying for graduate medical education is central to this strategy. Payments should be made for training in the ambulatory-care sites necessary for adequate primary care training, not just for intensive high-technology care in teaching hospitals. Payments should not reward expansion of the number of highly specialized residents. And, additional support to develop primary care research is needed to enhance knowledge in the field and attract the best and brightest students.

Second, federal action is needed to assure that we have an appropriate health care workforce in the future -- neither the current market forces nor foreseeable changes in the health care market will produce the mix of practitioners necessary to serve patient care needs. Much of the expansion of highly specialized medical practice in the past several decades was made possible by the type of health insurance coverage that most Americans had, indemnity plans that paid on a fee-for-service basis. In recent years, more and more Americans have had their coverage changed to a wide array of managed care plans -- HMOs, PPOs, and other arrangements that limit utilization and specialty referrals. Some group- and staff-model HMOs that employ their own doctors or otherwise limit the number of physicians available to subscribers now report a shortage of available primary care practitioners. In response, these HMOs have put together aggressive recruiting packages, including high initial salaries for new graduates of primary care residencies. Other managed care entities are buying up established primary care medical practices at a rapid rate.

These developments have led some to suggest that the private sector will modify the training of specialists on its own in response to these changing market forces. As a result, they argue, federal intervention will not be necessary. Unfortunately, that optimistic view fails to consider the most important factors that

determine the rate of production of nonprimary care specialists -- the financial and professional self-interests of teaching hospitals and training programs.

Anecdotal reports about developments in the job market for primary care practitioners are unlikely to have a substantial effect on clinical program directors in teaching hospitals who work to maintain the size of their residency programs at nearly all costs. Nor will they deter hospital administrators who rely on specialty services to generate revenues. The specialty societies and boards themselves have been extremely reluctant to introduce restrictions on their numbers, in part out of antitrust concerns. Third- and fourth-year medical students who have been indoctrinated into the high status and lucrative future of the high-technology specialties -- and who are counting on high earnings to pay their medical school debts -- will continue to respond to those forces.

Moreover, even if the market did work, it would take so long that far greater excess numbers of specialists would be trained in the meantime. Enrollment in group and staff model HMOs and other relatively tight managed care plans cannot suddenly replace indemnity fee-for-service coverage overnight. It could well take five to ten years to get the bulk of workers into such plans. Many parts of the country do not lend themselves to the urban large HMO model, and many consumers would resist such a trend.

Recognizing the need for public intervention into the training of specialists, some states have taken measures to affect the distribution of trainees. These measures can only affect what goes on within state borders, however, and will have little overall effect.

If growth in primary care is to be enhanced and in nonprimary care specialties is to be restricted, there is a clear need for new federal policy. The distribution of specialists needs to be determined on a national basis, to serve national health care needs rather than the parochial interests of teaching hospitals and their training programs.

Third, federal action will be effective and need not be overly intrusive or heavy-handed. The federal government can take steps that will effectively redirect the training of specialists. First, the number of practitioners needed in each field can best be forecast on a national basis. Then, the flow of training funds can be directed to assure that they go toward meeting this goal. All of this can be done in a way that assures that the integrity and quality of specialty training is preserved, and that opportunities are not unfairly restricted.

Although substantial work needs to be done to develop the best implementation strategies, the time for further study of the problem has long since passed. It has been some two decades since the federal Graduate Medical Education National Advisory Committee (GMENAC) was established. In 1980 that advisory body forecast overall and specialty physician surpluses. In response, federal legislation created an advisory body, the Council on Graduate Medical Education (COGME), which has continued to study and monitor

the situation but has had little impact on physician supply and distribution in the face of countervailing federal policies and private incentives. Under Dr. Philip Lee's leadership, the Congressional Physician Payment Review Commission began its ongoing analysis of strategies for modifying physician specialization, and the Office of the Assistant Secretary for Health now has a major emphasis on this subject.

These federal experiences provide a sound basis for a thoughtful, reasonable approach to the predictably difficult task of cutting the training programs in certain specialties. A variety of models for the federal system could be developed, ranging from highly centralized to largely decentralized. With substantial private sector involvement, the traditional professional lines of decisionmaking need not be highly disrupted. The prospect of such involvement has grown recently. Unlike their posture for many years, many of the affected specialties, training programs, and academic health centers now seem poised to cooperate with appropriate federal measures.

Whatever system for implementing residency controls is put into place, the legislative tool to accomplish this task is simple: redirect training monies. Unlike the open-ended approach that has characterized Medicare GME payments, future payments for specialty training should only be made to programs whose physician training furthers the national policy. Public funds should no longer be used to subsidize the production of unwanted numbers of specialists who will continue to drive up health care expenditures and frustrate reform efforts.

In addition, the benefits of being included in health plans under the new system should only be available to training sites that participate in the national program. Without this lever, training programs will simply use the public support for approved residencies, and will keep unapproved ones going with patient care revenues. Permitting such back-door funding would seriously hamper or undermine the new policy. Since virtually all of those patient care dollars that would be used will be either public funds or funds being spent under the federal mandate, programs should use those funds to further the national purpose and not to continue specialty expansion.

Fourth, health care reform itself will be jeopardized by failing to reform the workforce. One further consequence of failing to bring the production of specialists into line with overall federal policy is that the continued production of more and more practitioners in the high-technology procedural specialties will make it all the more difficult to control spending and achieve universal coverage. We physicians have proved quite enterprising in finding ways to be paid to put our training into practice, whether needed or not. The more surgeons, the more surgery; the more gastroenterologists, the more fiberoptic tubes find their way into gastrointestinal tracts.

A substantial excess of specialty care in active practice inappropriately defines what care is needed. If the standard in

the fee-for-service sector is excessive care, it is all the more difficult for HMOs and other managed care systems to set more rational standards. Similarly, it is more difficult to develop and expect physicians to follow more rational medical practice guidelines if the standard of practice reflects the supply of physicians and technology more than the needs of patients. Allowing the surfeit of highly specialized physicians to continue to grow will sustain pressures against a system of care based on sound scientific knowledge and reasonable medical decisionmaking.

Finally, in the absence of sound national policy, hundreds of thousands of highly trained physicians will not readily suffer the prospects of limited opportunities. Even as their numbers have skyrocketed in recent years, highly specialized physicians have been able to achieve a remarkable and sustained growth in their incomes relative to those of primary care physicians. Having survived more than seven years of advanced training, specialized physicians quite reasonably are likely to resist the expansion of managed care plans and cost-containment measures that they perceive as likely to curtail further growth in their earnings. Federal funds have too long been used to create this well-heeled constituency with strong interests against reform. Continued expansion of their numbers will only exacerbate both their motivation and their numbers.

CONCLUSION

Time and again, the Congress -- this Subcommittee in particular -- has recognized the importance of federal direction and support in the training of health professionals. The programs in Title VII and Title VIII of the Public Health Service Act, the incentives built into the RB/RVS system of paying physicians under Part B of Medicare, the modest adjustment of Medicare GME payments in the direction of primary care, and the long history of support for the construction and expansion of medical schools and teaching hospitals are all testimony to Congress's commitment to ensuring that the health professionals of this country serve the nation's needs. Now, as you address the pressing need to enact comprehensive health care coverage for all, you have the opportunity to assure that the system of training health

professionals will be able to achieve a remarkable and sustained growth in their numbers. Even as their numbers have skyrocketed in recent years, highly specialized physicians have been able to achieve a remarkable and sustained growth in their incomes relative to those of primary care physicians. Having survived more than seven years of advanced training, specialized physicians quite reasonably are likely to resist the expansion of managed care plans and cost-containment measures that they perceive as likely to curtail further growth in their earnings. Federal funds have too long been used to create this well-heeled constituency with strong interests against reform. Continued expansion of their numbers will only exacerbate both their motivation and their numbers.

Mr. WAXMAN. Thank you, each of you, for your testimony. You have given us excellent testimony.

Dr. Bondurant, you mentioned if we had managed competition in pure form, all the market forces operating, that it would be devastating to our academic institutions. The President's bill, however, tries to modify the competition by providing a stream of money for graduate medical education and direct subsidies to academic health centers. At its full implementation that would come to about \$10 billion.

I wonder if you would each comment on the funding question and, if you believe the administration's financing is not adequate, do you have any estimates about what amount would be sufficient to ensure a reasonable and stable transition to achieve our work force goals?

Mr. BONDURANT. If I can start off, Mr. Chairman, we believe that the intent of that funding is to level the playing field and is to compensate the academic institutions for services that they render that would be disadvantaged in the competitive mode. As implied by your question, we feel that those funds are substantially underfunded and do not recognize monies that are now in the system.

With respect to the GME funding, the data we know suggests between 20 and 30 percent of the GME costs today are borne by Medicare and Medicaid. So that between 67 and 80 percent of the GME costs are borne by other funders. As we understand the bill, the provisions for additional funding from the alliances do not come close to meeting that, do not come close to meeting that sum.

With respect to the indirect medical education fund, the bill, as you know, proposes a reduction in that fund from approximately 7.7 percent plus to something like 3 percent, without inflating the dollars over time, I believe. And those monies are, in some sense, as you know, not precisely labeled. They are the monies that are used by our teaching hospitals to assure that Medicare beneficiaries and others have the full benefit of the services that are necessary in those hospitals.

With respect to the other category of funds, the AHC funds, the reason those funds are now budgeted to go up to, it is \$4.8 billion, I guess—a recent study by Lewin-VHI suggests that a more realistic number for 1991 was between \$9 billion and \$10.6 billion going into the system for that purpose from all payers presently. So that those three funds are, those two funds are grossly underfunded.

I mentioned also the fact that specific losses incurred by the medical schools under this plan nowhere appear as such in the plan, and those losses would be substantial, and those funds are absolutely essential if our medical schools are to continue the basic education in primary care on which health care reform depends.

Mr. WAXMAN. Dr. Bulger, do you want to respond.

Mr. BULGER. First of all, I want to thank you for such an easy question. I appreciate that. And I can associate myself with much of what Dr. Bondurant says. We are operating from the same figures.

I think just two things I would like to add is that my understanding is that the direct medical education calculation was fundamentally the same as what is going on now with the Medicare direct medical education, although reduced from what was a

\$64,000 average per resident to \$53,000. So one could say that, clearly, if we were going to stay up to where we were, one would like to see it be a little bit higher.

The complication in this funding, though, that I would like to emphasize in my answer to you, is that we have not really figured out how to translate the cost of education and the payment for this into the primary care setting. In other words, in the best I can tell, it is every bit as expensive.

Let me just give you an idea of what I am driving at. For years, I understand Hippocrates' people have been saying it is your obligation to train the next generation of physicians, and physicians have done that and do it for nothing. They give their time. But as I go around the country and hear from colleagues who are experiencing the managed care wave, the sweep, they are all saying that the people who have been the bedrock of their clinical education system, those who give it free, give their educational services in a sense free in their offices, are saying we cannot do it any more under the efficiency mode of managed care. So I think there is a problem in here of how to switch from where we are to this.

And let me make one last comment, and that is that 80 percent of our members voted for what had been a third setaside for public health and health services initiatives, which I know everybody wants, and they believe that it would be very much to everybody's advantage to be able to put that back into an entitlement dimension, which further complicates the dynamics, I know.

Mr. BUDETTI. Mr. Chairman, when I look at \$10 billion, it looks like a lot of money. I think that the way that the figures are being calculated does not adequately reflect the availability of money. I think that when you look at some teaching hospitals that have been done extremely well under the current system, that have amassed major surpluses in the hundreds of millions of dollars, in salary for some clinical faculty as high as a million dollars, for faculty members, I think before you take at face value the arguments a great deal more money is needed to cover the costs of the academic health center and teaching hospitals enterprise, we need to look carefully at those costs to see what they are and see how they are distributed among different hospitals and health centers.

I do believe a great deal of money should go for this purpose. I do think that the public investment is an appropriate one. I do think it is important to put money into this activity, but I do think that, especially looking at all the other great needs we have in this country for health care delivery, that going beyond this figure on the order of 5 to 10 times, which is already in the President's bill, I think it would take a serious and more sober analysis than we have seen thus far to justify a much higher figure.

Mr. WAXMAN. Thank you very much.

Mr. McMillan.

Mr. MCMILLAN. Can you hear me? My light does not work here.

I want to thank you all for coming today, particularly Dr. Bondurant, whom I have known pleasantly for some time, and I really would just like to continue with the questioning in the vein of the Chairman. I have had a chance to read in some detail Dr. Bondurant's report, which I just received this morning, and I felt it was extremely well done and informative. This whole issue of

health care reform is enormously complex and the particular issue we are talking about today is enormously complex in and of itself.

The issue of funding of medical education in this country has been complex and somewhat obscure, I think, in the past. There are disproportionate payments made for purposes all throughout the system, and I don't think anyone argues with that, even if some of them may be justified. But if when we go back and take a look at what are we trying to do here, we have an opportunity to rationalize what perhaps was not rationalized previously.

I am not sure I heard a very clear statement of precisely what the level of Federal funding is for medical education today. Is \$10 billion an accurate figure?

Mr. BONDURANT. Certainly, I would say that is one component. That would be a number that would represent the components that are identifiable from these particular sources. There are, obviously, other sources as well. There are direct grants from the Department of Health and Human Services for support of particular kinds of medical education and I am sure there are a number of other sources.

Mr. McMILLAN. National Institutes of Health grants.

Mr. BONDURANT. Most of the training grants of the National Institutes of Health are medical or educational for very special purposes. I don't myself have a number to offer in response to that, and I wonder, Dr. Bulger, I don't know if you would.

Mr. BULGER. My understanding, if you asked me to answer your question on the basis of what I know on the top of my head, is that right now there are Medicare funds, direct and indirect medical education funds, transfers, in effect, to teaching hospitals for education of residents and for a number of educationally related activities, and those funds now are something like \$3.4 billion and \$1.8 billion, the direct being \$1.8 billion. That adds up to around \$5 billion from Medicare to our institutions. But that is only, that is sort of prorated for the Medicare population.

If you take all of our residents and applied those numbers for the whole population it gets up to the—

Mr. McMILLAN. Well, that is supposed to be a reimbursement for or an inducement to treat the Medicare-eligible population. Yet, we know that disproportionate share payments under Medicaid have gone from almost nowhere to \$17 billion, 50 percent of which goes to only four States, much of which flows right into medical education systems within those States. We debated that in this year's budget.

I think when we get back to look at this, we need to really look at this carefully, because one of the presumptions in the Clinton plan is that we are going to put a 1.5 percent surcharge on the regional health care alliances and a 1 percent surcharge on the corporate alliances and we are going to continue a payment inter-related with Medicare which they are not yet prepared to tamper with, which I think should be folded into the whole system.

The Clinton plan puts something like a 1 percent plus tax on aggregate medical transfers in the range of \$900 billion, which is about the \$10 billion figure that we are talking about. I think we need to sort of lay that out in a rational fashion so that we are not kidding ourselves.

While I don't argue with the need to subsidize medical education in this country it does bring me to the next question. The difficulty I have is when you begin to do that and develop a rational policy, then there are public expectations from medical education, the folks on primary care certainly being one of them. It strikes me that the medical schools in this country are going to have to lead the charge in developing the techniques to achieve cost effective delivery.

Do you see that being a public policy that we should lay on the medical schools in this country, and would be at least one piece of a rational approach to determining the level of funding for medical education?

Mr. BONDURANT. Well, I would say the intent of some of my opening comments was to say that I think that the medical schools will inevitably have to lead, first of all, in building a work force that is acceptable; second, in being part of the alliances or part of the plans; being integral to the delivery system in many ways. Much of the indigent care in this country is delivered in the teaching hospitals, as you know.

So my response to your question would be that the medical schools must assume leadership in many aspects of the health care reform undertaking, including those involved in the delivery of care.

Mr. McMILLAN. I could go through a long list of things that in my limited experience it seems that medical educators and teaching hospitals could provide. There is a need for practice guidelines all through the issue we are taking about. Who is going to establish them? Who will be the repository of what these guidelines are?

I know my time has expired, but I think you get the gist of what I am talking about and I don't think we have begun to address some of those things in the state of the legislation as it is.

Mr. WAXMAN. Well, just to take off on my second round where you left off, there seems to be a general agreement about the growing importance of primary care research to the success of health reform. Historically, health services research funding has been given a much lower priority than biomedical or clinical research.

How much additional support is necessary given the importance of outcomes research and health services research to improving the quality and containing health costs? Dr. Budetti.

Mr. BUDETTI. Yes, Mr. Waxman, that is a very important concern. I think that part of what I was addressing before is the fact that medical students don't have role models in terms of seeing sophisticated primary care research going on while they see a lot of biomedical research going on. If you look at how much money is going into biomedical research, if you compare the biomedical research at the NIH, it is on the order of \$10 billion, with the only estimate I have ever seen, which is about \$40 million, going into primary care research. Ironically enough, about half of the money that is going into primary care research, about \$20 million, is coming from the NIH, because even by spending only two one-thousandths of their budget on primary care research, they were able to provide more money than any other single source.

So if we increase the proportion of spending on primary care research substantially, it would still be well below what is being

spent in other areas and could do a great deal towards establishing the credentials of primary care researchers and the stature it takes for them to be really role models for students choosing to go into primary care. If you could increase primary care research from \$40 million fivefold, to \$200 million, it would be a landmark step forward and still be only a tiny fraction of what is being spent appropriately enough on biomedical research.

Mr. BULGER. I would certainly second that and make the observation that our institutions have been, if nothing else, very effective at seeing where the carrots are, seeing where the government leaders, through its institutions, are saying we should be going and then learning how to go there.

What you are asking of us, I would point out, is a sea change in most—both service delivery and in the kinds of research that we have been traditionally trained to do, and I think I am seeing equal institutions trying to change, trying to adapt and trying to really do what they can to be responsive, and I think they are the institutions we have got. And rather than scotch the whole thing, we need to try to turn these battleships around and operate them in the right direction, and I think this can be done. And I think health services research, and what you have said, what you could expect from university-based places in terms of guidelines and standards, ought to be one of our missions.

Mr. WAXMAN. I have one last question, but before I ask it of this panel I want to acknowledge the presence of a number of legislators from the Kingdom of Nepal and we are delighted to have you visiting with us today.

Now, I wanted to ask this panel about an article in The New York Times which reported on the fears of some of our area hospitals over the possible reduction in residency programs that would occur under the Health Security Act. It seems New York has, among several States, trained a significant number of international medical graduates.

I recognize we have discussed this issue on several occasions in the past, and I know that many of these residents from abroad have provided service to low-income uninsured patients. It seems to me we need to take another look at this issue as we act to provide universal coverage for comprehensive benefits.

I would like to ask a couple of questions. First, is it appropriate to reduce the current number of international medical graduates training in the U.S. if we had universal coverage, and would it be desirable to limit the number of specialty training slots to 50 percent of U.S. medical school graduates while allowing higher numbers of residency slots for international graduates who are willing to enter primary care?

Dr. Bondurant, do you want to take that one?

Mr. BONDURANT. Well, let's—your first question was is it appropriate to reduce the total number of residency slots in the United States to presumably something like the COGME recommendation of 110 percent of the graduates. It seems to me there are two issues that need to be separated.

The United States has the world's best medical education establishment. In a sense we have an exportable commodity in the capacity to educate physicians for the world. We cannot educate them

in the mode to be physicians for the U.S.; they need to be different for their own home countries. I would hope that we would not walk away from or forget our capacity to contribute to the health of the world through the education of non-U.S. citizens.

A whole other issue is the question of what should be the mix of U.S. citizens and non-U.S. citizens in the physician population of the country. If the number that has been advocated by COGME of 110 percent, if the residents are to be 110 percent of the schools' graduating classes, that would mean approximately a little less than 10 percent of the physicians of the country, in a State-to-State equilibrium condition, would be foreign nationals, would be individuals who were educated as physicians as foreign nationals and then came into the pool.

The AAMC supports the view that the ultimate size of the residency program should be approximately 110 percent of the graduates of U.S. medical schools and that premise, but I would like to emphasize it is with the understanding that we do not walk away from our opportunity and our obligation to educate physicians broadly for the world.

Mr. WAXMAN. Dr. Bulger.

Mr. BULGER. The comment I would make is that I think we should set some national manpower policies or health work force policies. One step in that is having a council that can, in fact, continuously monitor the situation and see where we are and make any adjustments. I think that to—and I am speaking as an individual here; there is no survey of our members; I am not sure what people think—but I think that to confuse a short-term need for service, a desperate need for service, with a rationale for large educational investments is a long-term mistake; that every doctor we train and educate has to then go out somewhere else.

So I think that the situations in many of our cities, and perhaps New York is the most dramatic of those, but there are going to be others that have to be dealt with sensitively and maybe require a different time frame and maybe require a different funding mechanism in order to keep those places viable. But I would hate to see that as the rationale for flooding an otherwise perhaps already crowded physician marketplace.

Mr. BUDETTI. Mr. Chairman, I would certainly agree with everything Dr. Bulger has just said. I think, not speaking for the other two, but I am sure each of us has done a great deal of time working with in-training programs in various public sites, and we are well aware of the great difference between training and service delivery or what ought to be a difference between training and service delivery.

And that is the beauty of addressing this issue in the context of comprehensive health reform, is that you can straighten those two issues out and make sure people in inner cities are not relying on residents in large hospitals to the maximum degree possible and that they get mainstream into excellent care.

But addressing the second half of your question as well, I think that it is possible to separate the two issues of the cap on the total number of residency slots from the issue of the distribution of residencies among specialties. And I think that the tone of your question implies that it would make sense if we put a cap only on

specialties other than primary care and then let the number of residents who entered or physicians who were seeking training enter into as many of the nonsubspecialties and nonprocedural specialties as they wanted to. I think that is a thoroughly rational approach.

I think that there are reasons to consider the two at the same time, cutting the total number of residency slots and the allocation among resident specialties, but I think it is perfectly reasonable to separate those two as well; have one policy that says what we want to accomplish is to reduce the number of people going into nonprimary care residencies and maybe a separate policy that says we want to also address the total number of people entering into training programs in a way that is not totally disruptive.

Mr. WAXMAN. Thank you very much. Mr. McMillan.

Mr. MCMILLAN. One of my concerns with the shape of the Clinton plan as it is now is that it concentrates rather than diversifies and will eliminate competition rather than foster it. I think that is what we are trying to do, is to achieve a more diversified competitive response. This is something I am sure we will be debating.

But if we did succeed in empowering the individual to make choices and have the wherewithal to pay for it, basically meanstesting across the system, so long as it is only spent for what are deemed to be acceptable standard plans, then do you think that would engender a competitive response that would allow the free market out there to determine the relative composition of primary care physicians and specialists; that would engender competition upon managed care providers out there in the cities and towns across the country; that would enable teaching hospitals, that you represent, to respond to them with programs, ideas, innovations to make the system more responsive and cost effective? Wouldn't this be better than the direction coming from a seven-person board sitting up here saying we are going to have—50 percent of the specialties of physicians are going to be specialties in five years, which would mean taking away a lot of specialty licenses or sending a lot of people back to school or something.

Do you see education being able to respond to, if it is truly empowered to pay for it, responding to a free decision-making process out there in an effective manner?

Mr. BONDURANT. Let me speak to that, if I may, in the context of this—sort of a little bit different spin than Dr. Budetti—than I put on a very near related question at first.

I believe that if the playing field is leveled by appropriate recognition of costs in the academic medical centers that are not now represented, that there is enough of a chance that the kind of market forces that you are alluding to will be operative, that it is worth waiting a year or so to see whether or not that will determine the distribution of physicians by specialty.

I would like to say that, having said that, and that is the position of the AAMC as well as a personal judgment, it is also the position of the AAMC consistent with Dr. Budetti's position, that, in fact, if that proves not to work, that it may be that the only way to do this is with a regulatory, from the top down—the only way to influence the distribution among specialties is with a top down ap-

proach. As you know, many States are now mandating, have State level legislation to that effect.

We are seeing, in the current senior class, I can tell you at the University of North Carolina, for example, this year, of the students who will match in March, 64 percent have indicated their intention to go into the primary care disciplines. That is a very different phenomena than what has happened before. I think it is partly responsive to social needs; they are responsible citizens and their response to that is where they are needed that they are doing that.

At the same time, I have to say that they know and understand that the marketplace is now paying more. Entry level wages are higher for primary care physicians than they are for cardiologists, for example, and that is known to the students choosing careers. That has never been the case before. In 1975, that was not the case and it has only been the case for the last few years.

So our view is there is a sea change that has occurred and we should give time to see, another year or so, to see whether that will carry or not.

Mr. BULGER. I would agree that we will be able to see a response to the marketplace when and if managed care really sweeps a given area. In other words, the way it is now, we can turn out people and they can go get a job and hang out their shingle anywhere. That has been the traditional way, and you have not been able to have the feedback and we have always felt we had too few. So the policies will always generate more.

We have not had guidelines about what is too many. Now some studies come along, but now the marketplace changes and people cannot practice unless they sign up in a group or sign up and move into something. And one envisions a situation where you can look at the State of X and say we are going to have this number of doctors going out of practice this year; that is how many we need coming in. And we may not be that precise but it will be quite precise, and the pressure will be back on the medical schools and other schools to really adjust to the needs of the systems out there that are delivering the care.

I tend to think we need to, in order to go forward, have to have a body put in place, because I think we are asking too much of everyone else to believe that we will do that and that we can respond that way because there really has not been any evidence as yet that we have. And if we are right, we will respond before the council gets in shape and does move regulating, and if we have, that will be great.

And I think even then we will need some sort of group looking out over the whole picture, even though the manpower stuff is, in general, outside of physicians and even there to some extent, it is a State or a local issue rather than a kind of a national issue. A national board cannot decide how many nurse practitioners we need or PA's; that is all going to be done in southern California or in Idaho the way they want to do it and that is the way it ought to be.

Mr. BUDETTI. Mr. McMillan, I would love to think either a year would be enough time or we would have the kind of incentives that would turn things around fairly quickly. But I am afraid my view

is that I am sure many places in North Carolina, it would be extremely unlikely that 100 percent of the population would be in managed care any time soon or that that would be likely to, in fact, ever happen because of the way the population is distributed into small towns and rural areas.

I think the reality is that we will have a great number of people, even optimistic projections forecast 5 to 10 years to get even the majority of workers into the kind of managed care plans we are talking about that really allocate per number of physicians what we have been talking about.

In the meantime, we have increased an awful lot of specialists, and one of the problems with the specialists—gastroenterologists out there, for example. People with stomach aches go to a gastroenterologist long before they are ever told maybe what they really needed was some family counseling to deal with problems that are causing them to have pains in their stomachs. They will have run up hundreds or thousands of dollars with the gastroenterologists doing their best to find an organic problem with them and not ever find it.

And that is the difference between having a specialist available when you need it and having so many specialists out there that the standard of practice becomes unnecessary care. And managed care, then, has trouble trying, and medical practice guidelines have a great deal of trouble trying to rationalize the practice of medicine if the standard is greatly excessive practice because of the number of specialists we have out there.

So I am afraid the timing is difficult and it would take so long that we would have an even bigger problem than we have today in terms of nonprimary care specialists dominating the marketplace.

Mr. McMILLAN. If I could just conclude, in my own community of Charlotte, the changes are taking place so fast in combination between hospitals and practicing physicians and contractual relationships between central city hospitals and rural hospitals that the average person cannot keep up with it.

I have good friends who are supposed to know their way around; cannot find the primary care physician; don't know where to turn. Their primary care physician is aging out and they do not want to be treated by someone in the grave and have trouble finding—it is changing dramatically and I don't think we legislatively have the wisdom to predetermine the direction that needs, or maybe general directions, but if we can put the right incentive in place that encourages what we are talking about today—medical schools or teaching hospitals to get into the middle of moving this change, of being a part of the dynamic—then I think we will be doing the best that we can do, and that is really the thrust of my questioning.

Mr. WAXMAN. Thank you very much, Mr. McMillan.

I want to thank the three of you very much for your testimony. You have given us a lot of good information.

Mr. BONDURANT. Thank you, Mr. Chairman.

Mr. BUDETTI. Thank you.

Mr. WAXMAN. Our next panel includes organizations representing the health professions. Dr. Jan Towers is Director of Government Relations, Practice and Research at the American Academy of

Nurse Practitioners. Debra Bash is a certified nurse midwife who is the Director of the Graduate Program in Nurse-Midwifery at Georgetown University and is representing the American College of Nurse-Midwives. Dr. Paul Ebert—if he's still here; I heard he might have to leave—is Director of the American College of Surgeons, and if he is not here I understand James Haug, Director of the Socio-economic Affairs Department of the American College of Surgeons will testify for him. And then Dr. William Jacott is Vice Chair of the Board of Trustees of the American Medical Association and Assistant Vice President for Health Sciences at the University of Minnesota.

We are pleased to welcome you to our hearing today. Your prepared statements will be in the record in full. We would like to ask you to limit the oral presentation to no more than five minutes.

Dr. Towers, why don't we start with you.

STATEMENTS OF JAN TOWERS, DIRECTOR, GOVERNMENTAL AFFAIRS, PRACTICE AND RESEARCH, AMERICAN ACADEMY OF NURSE PRACTITIONERS; DEBORAH BASH, ON BEHALF OF AMERICAN COLLEGE OF NURSE-MIDWIVES; PAUL A. EBERT, DIRECTOR, AMERICAN COLLEGE OF SURGEONS; AND WILLIAM E. JACOTT, VICE CHAIR, BOARD OF TRUSTEES, AMERICAN MEDICAL ASSOCIATION

Ms. TOWERS. I am here today on behalf of the American Academy of Nurse Practitioners to speak to the issue of the projected role of nurse practitioners in the proposed health care reform in this country. It has been estimated if health care reform is fully implemented as proposed an additional 175 million patient visits per year will be generated by the year 2000. Even if noncompliance rates were built in, that figure is estimated to be 105 million. This will require approximately 37,000 new primary care providers to provide needed primary care services by that year.

Certified registered nurse practitioners are primary care providers who are able to provide quality, cost-effective primary care services to men, women and children of all ages and walks of life. It has been projected they are capable of handling 80 percent of all primary care services needed by families and individuals in a primary care practice. If utilized appropriately, nurse practitioners can make a significant contribution toward providing quality primary care services at a cost savings to the Nation.

Certified registered nurse practitioners provide primary care services focusing on health promotion and disease prevention as well as the diagnosis and management of acute episodic and chronic diseases. Currently, over 80 percent of the more than 30,000 nurse practitioners in the country are providing services in public and private primary care settings. Over half provide services to the medically underserved. The majority of nurse practitioners are family nurse practitioners. Women's health, pediatric and adult nurse practitioners make up the next largest nurse practitioner specialties.

Numerous studies document the quality of care provided by nurse practitioners. Surveys of the research and literature examining nurse practitioner practice found the quality of care provided by nurse practitioners was equal to that of physicians managing

the same conditions. Less than 1 percent have ever been named as primary defendants in malpractice cases. Likewise the level of patient satisfaction has been found to be extremely high.

Nurse practitioners have been found to be cost effective. They often charge less for their services. It costs less to prepare them, and in practices where they are used, patients have been found to have fewer days of hospitalization than in practices where they are not used.

According to Federal projections, the number of nurse practitioner graduates will need to be increased significantly to meet the projected patient needs when the Nation's uninsured are able to access primary care services through a national reform health care plan. In order to accomplish this, significant additional funding for educational program support, including start-up funds, funds for faculty development, and funds for work force analysis and planning activities, scholarships and traineeships will be needed to prepare additional nurse practitioners and faculty to meet these needs. In addition, to ensure full utilization, nurse practitioners must be able to practice within the full scope of their professional abilities. It is, therefore, important that the legislation be constructed that will facilitate the delivery of quality primary care services through the utilization of primary care providers such as nurse practitioners.

Nurse practitioners are supportive of the thrust and content of much of the Health Security Act as it is being proposed. The mandate to provide health and medical care to the Nation's uninsured is a welcome sight to professionals who have had to creatively provide care to the Nation's underinsured and uninsured in the past 30 years. Likewise, the specific inclusion of preventive care services in the basic care package is welcomed by nurse practitioners who have long fought for recognition of the worth of those services in the attainment of optimal levels of health for citizens of all ages and walks of life.

The additional services being offered in the treatment of mental health problems, dental care, and vision care are insightful and welcome to professionals such as nurse practitioners who have struggled with the inability of their patients to obtain such services in the past.

In addition, the recognition of the need for flexibility in implementation, the need to provide health care options for individuals, families and employers demonstrate the awareness of the administration to the variability in need and provision of services that exist in a widely disparate population such as ours.

The inclusion of antidiscriminatory language, the recognition of all primary care providers as participants in the system, the underwriting of educational preparation of nurse practitioners and the inclusion of Medicare reimbursement for reimbursable services provided by nurse practitioners regardless of setting, help to set the stage for the utilization of quality, cost-effective providers such as nurse practitioners in the new system.

Concerns of nurse practitioners regarding the proposed legislation include the need for strong enough incentives or mandates to ensure that providers such as nurse practitioners will not be excluded from the system. Currently throughout the United States

the nurse practitioners and nurse midwives have been excluded as providers from certain PPO's. Such closed door policies are destructive to the concept of full utilization of quality, cost-effective primary care providers. They provide evidence of the damage special interest groups can impart on activities geared to strengthening primary care services in urban and rural populations. Such exclusions demonstrate the need for strong legislative language to prevent indiscriminate lockouts of systems of care provided by competent, cost-effective providers such as nurse practitioners.

For this reason, language regarding nondiscrimination, utilization of all primary care providers, loosening antitrust laws, structuring of health care alliances must be examined closely and worded carefully so that exclusions cannot purposefully be implemented.

Likewise, mandated inclusion of nurse practitioners as specified members of boards and commissions that oversee and facilitate the implementation of this legislation should be considered. And, of course, the fate of special populations such as the homeless, migrant kids in school-based clinics who do not fit easily into traditional HMO-managed care frameworks is of concern to us.

Mr. WAXMAN. Thank you very much for that testimony. We will have it all in the record.

[The prepared statement of Ms. Towers follows:]

STATEMENT OF AMERICAN ACADEMY OF NURSE PRACTITIONERS

I am here today in behalf of the American Academy of Nurse Practitioners to speak to the issue of the projected role of nurse practitioners in the proposed health care reform in this country. It has been estimated that if Health Care Reform is fully implemented as proposed an additional 175,000,000 patient visits per year will be generated by the year 2000. Even if noncompliance rates were built in that figure is estimated to be 105,000,000. (1) This will require approximately 37,000 new primary care providers to provide needed primary care services by that year and does not account for any specialty care that would subsequently be needed by patients being seen.

Certified registered nurse practitioners are primary care providers who are able to provide quality, cost effective primary care services to men, women and children of all ages and walks of life. It has been projected that they are capable of handling 80% of all primary care services needed by families and individuals in a primary care practice (2,3,4). If utilized appropriately, nurse practitioners can make a significant contribution toward providing quality primary care services at a cost savings to the nation.

Certified registered nurse practitioners provide primary care services focusing on health promotion and disease prevention as well as the diagnosis and management of acute episodic and chronic disease (5). They take medical histories, perform physical examinations, order, perform and interpret diagnostic tests, prescribe medications and other treatments for the patient based on their diagnoses and provide counseling and preventive health education for patients coming to their care.

Currently over 80% of the more than 30,000 nurse practitioners in this country are providing services in public and private primary care settings (6). Over half provide services to the medically underserved. The majority of nurse practitioners are family nurse practitioners. Women's Health, pediatric and adult nurse practitioners make up the next largest nurse practitioner specialties; gerontologic nurse practitioners comprise the smallest group (6).

Numerous studies document the quality of care provided by nurse practitioners. Surveys of the research and literature examining nurse practitioner practice found that the quality of care provided by nurse practitioners was equal to that of physicians managing the same conditions. Less than 1% have ever been named as primary defendants in malpractice cases. (7) Likewise the level of patient satisfaction was found to be high (2,3,4).

Nurse practitioners have been found to be cost effective; they often charge less for their services (8); it costs less to prepare them (2, 4) and in practices where they are used, patients have been found to have fewer days of hospitalization than in practices where they are not used (8).

According to federal projections the number of nurse practitioner graduates will need to be increased significantly to help to meet projected patient needs when the nations uninsured are able to access primary care services through a national reformed health care plan. In order to accomplish this, significant additional funding for educational program support(including start up funds, funds for faculty development and funds for workforce

analysis and planning activities), scholarships and traineeships will be needed to prepare additional nurse practitioners and faculty to meet this need. In addition to insure full utilization nurse practitioners must be able to practice within the full scope of their professional abilities.

As the proposals for health care reform unfold, it has become clear that the need for increased primary care services throughout the United States has been recognized. Likewise there appears to be a recognition that the nation's 37 million uninsured population will need legislative backing to insure that they will be able to participate in those primary care services once they are offered. Those services must be provided in cost effective ways while at the same time maintaining high standards and quality of care. Nurse practitioners have been considered to be a viable option in the provision of this kind of care to the nation's underinsured and underserved. Given this framework, it is important that legislation be constructed to facilitate the delivery of quality primary care services through the utilization of primary care providers such as nurse practitioners.

Nurse practitioners are supportive of the thrust and content of much of the Health Security Act as it is being proposed. The mandate to provide health and medical care to the nation's uninsured is a welcome sight to professionals who have had to creatively provide care to the nation's uninsured and under insured in the past 30 years. Likewise, the specific inclusion of preventive care services in the basic care package is welcomed by nurse practitioners who have long fought for recognition of the

worth of those services in the attainment of optimal levels of health for citizens of all ages and walks of life. The additional services being offered in the areas of treatment of mental health problems, dental care and vision care are insightful and welcome to professionals such as nurse practitioners who have struggled with the inability of their patients to obtain such services in the past.

In addition, the recognition of the need for flexibility in implementation, the need to provide health care options for individuals, families and employers demonstrates the sensitivity of the administration to the variability in need and provision of service that exists in a widely disparate population such as ours. Hopefully, this Act will allow for new and innovative health care delivery systems to be implemented in the provision of primary care services throughout the country and particularly in the Commonwealth of Pennsylvania.

The inclusion of antidiscriminatory language, the recognition of all primary care providers as participants in the system, the underwriting of educational preparation of nurses practitioners and the inclusion of Medicare reimbursement for reimbursable services provided by nurse practitioners regardless of setting, help to set the stage for the utilization of quality, cost effective providers such as nurse practitioners in the new system.

Concerns of nurse practitioners regarding the proposed legislation, include the need for strong enough incentives or mandates to insure that providers such as nurse practitioners will not be excluded from the system. Currently throughout the United

States, nurse practitioners and nurse midwives have been excluded as providers by certain PPOs. Such closed door policies are destructive to the concept of full utilization of quality, cost effective primary care providers. They provide evidence of the damage special interest groups can impart on activities geared to strengthen primary care services in urban and rural populations. Such exclusions demonstrate the need for strong legislative language to prevent indiscriminate lockouts of systems of care provided by competent, cost effective providers such as nurse practitioners.

For this reason, language regarding nondiscrimination, utilization of all primary care providers, loosening of antitrust laws and structuring of health care alliances must be examined closely and worded carefully so that exclusions cannot be purposefully implemented. Likewise mandated inclusion of nurse practitioners as specified members of boards and commissions that oversee and facilitate the implementation of this legislation should be considered. The knowledge and expertise of nurse practitioners in the primary care arena will need to be utilized fully in the development of policy as well as the provision of services, if primary care is to be delivered in a manner that recognizes the full scope of the involved services.

Nurse practitioners have been providing primary care services to their patients for years. Often they have had to do so with one hand tied behind their backs because of arbitrary barriers to their practice. It is known that nurses are willing to enter educational programs to become nurse practitioners. Many of the programs

preparing nurse practitioners currently have waiting lists of potential students. The proposed legislation can facilitate the provision of high quality, primary care to all populations through the appropriate utilization of nurse practitioners. It is an enormous task that will require the cooperation and collaboration of all primary care providers regardless of professional orientation or preparation. There is more than enough work to go around for all recognized primary care providers. Nurse practitioners are willing to contribute to what it takes to see that our citizens receive quality primary care. We want to help, but we will need help to do it.

We thank you for the opportunity to provide testimony this morning. If you should desire more information, we will be very willing to provide it.

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Mr. WAXMAN. We would next hear from Ms. Bash.

STATEMENT OF DEBCRAH BASH

Ms. BASH. I am most pleased to speak to you on behalf of the American College of Nurse-Midwives, which represents over 4,500 certified nurse-midwives in the United States.

The American College of Nurse-Midwives is pleased to endorse President Clinton's Health Security Act. We believe that health care is a basic human right. We agree with the reform proposal's seven basic principles, especially the removal of some of the barriers to nurse-midwifery practice.

In the first large scale, national study describing nurse-midwifery care to vulnerable populations, funded by the Robert Wood Johnson Foundation and published in the *Journal of Nurse-Midwifery*, data about these women, the settings in which they receive care, and the financing of their care is described. More than two-thirds of the clients seen by nurse-midwives are categorized as "vulnerable" by one or more criteria.

The findings of this study suggest that CNM's, as a group, make a major contribution to the care of vulnerable populations. Nearly half of all nurse-midwifery patients and nurse-midwives report a prime work site that is located in a federally designated health professional shortage area.

The American College of Nurse-Midwives are pleased to see that the Health Security Act recognizes nurse-midwives as essential community providers; however, like any legislation, some parts need some fine-tuning. Given on a national level that over 50 percent of our reimbursement of our services comes from Medicaid and other government subsidized sources, we have concerns that under the new proposed structure vulnerable and underserved populations will not have access to CNM's.

Sections 1581 through 1585 of HSA set forth definitions and standards regarding institutional and professional providers who qualify for the designation as "essential community providers."

The ACNM is pleased to know that certified nurse-midwives are among those professionals eligible for this designation which recognizes the important role nurse-midwives play in providing primary health care services to women and infants who are in underserved population groups or who otherwise lack access to health care services.

While ACNM strongly supports this program, we are, nevertheless, concerned that freestanding birth centers are not included as a category of institutional provider in the current version of the HSA. Mr. Chairman, freestanding birth centers should be included as a category of provider which will be automatically certified pursuant to the terms of section 1582(a).

ACNM also supports section 1431 of the HSA, which assures that health plans will not discriminate against essential community providers, such as certified nurse-midwives. We also believe that this section should include an additional provision which would require plans to ensure that all hospitals which participate in the health plan must permit CNM's and other essential community providers to obtain independent admitting privileges. Our clients cannot be left outside if they need or choose to go to the hospital centers.

One of the major barriers to the expanded utilization of certified nurse-midwives is lack of or inadequate reimbursement of services. However, in 1987, Congress set the CNM reimbursement rate under Medicare at 65 percent of the physician fee schedule. This rate creates a significant financial burden for CNM's. Coupled with low levels of Medicaid reimbursement in many States, this burden creates a major barrier for CNM's providing services to vulnerable populations. House bill H.R. 2386 and Senate bill 833 include provisions to pay nurse-midwives, nurse practitioners, and clinical nurse specialists at 97 percent of the Medicare physician fee schedule. We seek your support for this legislation.

Freestanding birth centers also suffer from lack of or insufficient payment. As noted in the Physician Payment Commission report to Congress in 1993, only 24 State Medicaid programs provide payment for facility costs of birth centers.

As the Nation moves into managed care and a managed care model of health care delivery, we wish to illustrate how nurse-midwifery care in a freestanding birth center is compatible with this model.

In the written testimony before you, we have given an example of how an alternative care program can be mainstreamed into an integrated managed care system. The Birth Place in San Diego, Calif., was developed to address lack of access to prenatal care for women and newborns. They found a solution, an integration of four health care systems.

Mr. Chairman, last year a national advisory group on work force projections was established in the Bureau of Health Professions. A broad based nursing coalition of professional associations has been established to determine what this program might look like, and we are working on it now.

Before I conclude I want to share with you that the ACNM is greatly concerned that the present version of the administration's bill appears to grant an extensive and open-ended antitrust exemption for profit negotiations. ACNM has consistently opposed antitrust legislation in connection with health care reform. We believe that existing payment methodologies are adequate and appropriate for development of regional or State fee schedules.

Finally, and on behalf of the American College of Nurse-Midwives, I would be pleased to answer any questions, or provide additional information. You have before you our written testimony. Thank you.

Mr. WAXMAN. Thank you very much. Appreciate your testimony, and that written testimony will be in its entirety in the record and we will share it with the other members of the committee.

[Testimony resumes on p. 488.]

[The prepared statement of Ms. Bash follows:]

STATEMENT OF AMERICAN COLLEGE OF NURSE-MIDWIVES

INTRODUCTION

I am most pleased to join you today on behalf of the American College of Nurse-Midwives, which represents over 4500 certified nurse-midwives (CNMs) in the United States.

HEALTH CARE REFORM

ENDORSEMENT OF CLINTON PLAN

The American College of Nurse-Midwives (ACNM) is pleased to announce its endorsement of President Clinton's Health Security Act.

The College believes that health care is a basic human right. This reform proposal addressed seven basic principles that any reform proposal must contain in order to meet the major challenges facing the health care system. These are: universal coverage; access to care; a comprehensive package of benefits including primary and preventive health services; a strengthening of community-based infrastructures for the delivery of care to women and children, particularly to vulnerable and underserved populations; an increase in the supply and distribution of appropriate health personnel; transition mechanisms to comprehensive reform; and removal of some of the barriers to nurse-midwifery practice.

THE POPULATIONS NURSE-MIDWIVES SERVE

VULNERABLE POPULATIONS: RWJ STUDY

Findings from the 1991-92 research study "Nurse-Midwifery Care to Vulnerable Populations in the U.S." provide an in-depth description of

the practice of nurse-midwifery. This study was funded by the Robert Wood Johnson Foundation, Grant # 18747. Phase I of the results were published in the September/October 1992 issue of the Journal of Nurse-Midwifery. Phase II has been accepted for publication in the January/February 1994 issue of the same journal. Additional findings are being prepared for submission to prominent medical and public health policy journals.

The study, "Nurse-Midwifery Care to Vulnerable Populations in the United States", is the first large-scale, national study to describe the amount of care provided by nurse-midwives to women from vulnerable populations, the characteristics of these women, the settings in which they receive nurse-midwifery care, and the financing of their care. For purposes of this study, "vulnerable populations" are defined as populations that are likely to experience poorer than average outcomes of pregnancy by virtue of their age, race/ethnicity, source of payment, geographic location, and immigrant/migrant status. The study also obtained prospective data about the components of clinical services provided to women and infants by CNMs and the amount of time spent providing services in a variety of settings.

Phase I

The following findings of Phase I of the study suggest that CNMs, as a group, make a major contribution to the care of vulnerable

populations:

- 99% of the CNM respondents serve women with at least one of these vulnerable characteristics
- 70% of all visits to CNMs are made by women or infants with at least one vulnerable characteristic
- 34% of the women cared for by the nurse-midwives in the study live in inner-city areas
- 22% of the women cared for by the nurse-midwives in the study live in rural areas
- over 1/3 of the clients seen by CNMs are living in areas where a higher than average number of people are living below the poverty level
- 69% of CNMs report that part of their income comes from Medicaid payments
- on a national average, approximately 47% of reimbursement for CNM services comes from Medicaid and other government-subsidized sources, 19% from private insurance, and 15% from HMOs

ESSENTIAL COMMUNITY PROVIDERS

ACNM was pleased to see that the Health Security Act recognized CNMs as essential community providers. However, like any legislation it needs some fine tuning. Given on a national level that over 50% of

reimbursement for our services comes from Medicaid and other government subsidized sources, we have concerns that under the new proposed structure, these populations will not have access to CNMs.

Sections 1581 through 1585 of the HSA set forth definitions and standards regarding institutional and professional providers who qualify for designation as "essential community providers". Certified nurse-midwives are among those health professionals who are eligible for this designation, which recognizes the important role nurse-midwives play in providing primary health care services. CNM eligibility as essential community providers assures that such services are available for women and infants who are within underserved population groups or who otherwise lack access to health care services.

While ACNM strongly supports this program, we are, nevertheless, concerned that freestanding birth centers are not included as a category of institutional provider in the current version of the HSA. Freestanding birth centers should be included as a category of provider which will be automatically certified pursuant to the terms of section 1582(a).

ACNM also supports section 1431 of the HSA, which assures that health plans will not discriminate against essential community providers. These assurances include such points as equality with other providers regarding level of payment, recognition of the full scope of services for which payment will be made, and equality of access to specialists. In

addition, gatekeeper restrictions will not be applicable for consumers seeking access to these categories of providers. We believe, however, that this section should include an additional provision, which would require plans to ensure that all hospitals which participate in the health plan, must permit CNMs and other essential community providers to obtain independent admitting privileges.

Privately-imposed barriers continue to exist in the health care marketplace which prevent nurse-midwives from providing client care (services) within the full scope of their license to practice. A major barrier is the failure or refusal of health plans to reimburse for CNM services or to permit CNMs to join provider networks. Health reform legislation should prohibit regional and corporate alliances and all health plans (not only fee-for-service plans) from denying reimbursement or participating provider status to any type, class, or professional category of provider who provides covered services.

The benefits of nurse-midwifery care will not be fully realized unless CNMs can have access to a health care market which is a "level playing field," which permits CNMs to offer their services in a variety of settings without artificial restrictions.

REIMBURSEMENT FOR SERVICES

Lack of reimbursement and inadequate reimbursement are major barriers to the expanded utilization of certified nurse-midwives. More

than 10 years after mandating reimbursement to CNMs for maternity services, Congress included payment to nurse-midwives for services outside the maternity cycle under the Medicaid and Medicare programs in the Omnibus Budget Reconciliation Act of 1993.

However, in 1987, Congress set the CNM reimbursement rate under Medicare at 65% of the physician fee schedule. This reimbursement rate, which has been adopted by many private insurance companies, and now CHAMPUS, creates a significant financial burden for certified nurse-midwives. This burden, coupled with low levels of Medicaid reimbursement in many states, creates a major barrier to the expansion of nurse-midwifery services to vulnerable populations. House bill H.R. 2386 and Senate bill S. 833 include provisions to pay nurse-midwives, nurse practitioners and clinical nurse specialists at 97% of the Medicare physician fee schedule. We seek your support of this legislation.

Free-standing birth centers also suffer from lack of or insufficient payment. As noted in the Physician Payment Commission Report to Congress, 1993, only 24 state Medicaid programs provide payment for facility costs of birth centers. Recently, Oklahoma brought this total to 25. With respect to other Federal programs, CHAMPUS will pay such facility costs, while Medicare will not. All federal programs should uniformly provide for payment of facility costs for free-standing birth

centers.

As the nation moves into a managed care model of health care delivery, we wish to illustrate how nurse-midwifery care in a free-standing birth center is compatible with this model. The hallmark of nurse-midwifery practice throughout its history has been managed care, in the sense of providing specific components of care within an organized delivery system. The nurse-midwife managed free-standing birth center discussed here provides an example of how an alternative care program can be mainstreamed into an integrated managed care system.

The Birth Place in San Diego, California was developed to address lack of access to prenatal care in San Diego County. It has successfully integrated four health care systems:

- 1) A private practice of nurse-midwives and obstetricians,
- 2) The public community clinic system,
- 3) The tertiary university hospital, and
- 4) A free-standing birth center.

The Birth Place program provides a model of care which, if replicated, could help ensure universal access to maternity care in the United States. This program serves a primarily public-funded (95% Medi-Cal), and predominantly Hispanic population. Certified nurse-midwives are the primary providers.

There were 16,580 admissions to 40 freestanding birth centers

reported in the 1987-89 National Association of Childbearing Centers (NACC) Survey. The intrapartum transfer rate was 13% leaving 14,425 births in the survey. The figures below underrepresent the savings birth centers offer, because they do not include savings realized by a cesarean section rate of less than 5% and by the extra services included in the birth center packages (lab fees, childbirth education, newborn exams, home visits).

COMPARISON OF BIRTH CENTER CHARGES VS. HOSPITAL CHARGES

Computation (Average Rates)	Total Charges For 14,425 Births	A Birth Center Would Have Saved	Savings Per 1000 Births
At Birth Center Rate (\$2377)	\$34,288,225		
At Regular Hospital Rate (\$4323)	\$62,359,275	\$28,071,050	\$1,946,000
At Hospital Short Stay Rate (\$3495)	\$50,415,375	\$16,127,150	\$1,118,000
At In-Hospital Birth Center Rate (\$3331)	\$48,049,675	\$13,761,450	\$ 954,000

If only 50% of the 4 million births that occur annually in the U.S. were attended in freestanding birth centers, the savings would be almost \$4 billion annually.

PROJECTED WORKFORCE - FUNDING FOR TITLE VIII AND GNE

Last year, a National Advisory Group on Workforce Projections was established in the Bureau of Health Professions to provide advice and assistance to the National Advisory Council on Nursing Education and Practice and the staff of the Division of Nursing. In addition to the members from the nursing profession, technical staff assistance was provided from the Division of Nursing; the Division of Medicine, Bureau of Health Professions; Office of Health Professions Analysis and Research, Bureau of Health Professions; National Health Service Corps, Office of Rural Health, Health Resources and Services Administration; and the National Institute of Nursing Research. The specific task of the workforce group was development of workforce projections based on the hypothesis that all Americans would have access to universal health care.

A preliminary report was released to the National Advisory Council on Nursing Education and Practice in December, 1993. The group projected that 9,000 more CNM full-time equivalency positions were needed by the year 2000. The National Commission on Nurse-Midwifery Education (convened in 1993) came to a similar conclusion. The Commission report demonstrated a demand for at least 10,000 practicing nurse-midwives by the year 2001. ACNM estimates between 3,500 - 4,000 practicing CNMs.

We commend the Administration's health care reform proposal for creating new monies for nurse-midwifery in a program similar to graduate medical education. A broad based nursing coalition of professional

associations has been established to determine what such a program might look like and we would be glad to provide specific information to you in the very near future. However, we do have concerns that although the new program would be established under the Health Security Act, we will still need additional monies in Title VIII to expand our education programs.

MODEL PRACTICE ACTS/RESTRICTIVE STATE LAWS

The Health Security Act seeks to eliminate practice restriction and barriers in state law, which we applaud. In general, however, equal or greater barriers exist in federal statutes and policies, including certain provisions of the HSA. Health care reform provides the appropriate opportunity to remove such barriers, while achieving other important reform goals of access and choice.

Furthermore, we have always supported state rights in defining the scope of CNM practice. We recommend that state incentives be developed to ensure that CNMs can practice within the scope of what they have been taught in nurse-midwifery school.

ANTITRUST EXEMPTION FOR PROVIDER NEGOTIATIONS

We are greatly concerned that the present version of the Administration's bill appears to grant an extensive and open-ended antitrust exemption. Section 1322(c) permits health care providers to agree among themselves on fee levels and then to negotiate with regional alliances over the fee schedule to be utilized by fee-for-service plans.

ACNM has consistently opposed any antitrust exemption in connection with health care reform. This remains our position. We believe that existing payment methodologies are adequate and appropriate for development of regional or state fee schedules. ACNM, therefore, opposes those aspects of section 1322(c) which would not only permit, but would encourage, health professionals and other providers to agree upon and fix fees when negotiating with alliances.

Much of our specific concern arises because the bill fails to provide any real supervision or control over provider conduct during this process and because the entire notion of provider antitrust immunity undermines an original intention of the health reform plan -- to create alliances of businesses and consumers which would be able to use their combined buying power to keep health care costs down. Under section 1322, however, physicians and other large groups of providers would be able to counteract the alliances' buying power.

Background. Earlier this year, the American Medical Association (AMA) and the American Hospital Association (AHA), along with other professional or trade associations, including the pharmaceutical manufacturers, sought exemptions from the antitrust laws under a reformed health care system. Such exemption proposals are nothing new, for various trade and professional associations have long sought antitrust exemptions which would permit them to engage in otherwise-illegal anticompetitive

conduct, such as price-fixing or exclusion of competitors.

The federal antitrust laws include the Sherman Act, the Clayton Act, and the Federal Trade Commission Act. These laws prohibit conspiracies and agreements in restraint of trade between two or more persons or entities, which is intended to or has the effect of restricting competition among themselves or preventing competition from other persons. These laws prohibit such activities as price-fixing, market division, "tying" (conditioning the sale of one product or service upon the purchase of another product or service), and group refusals to deal with competitors. Monopolization and attempts to monopolize, as well as mergers which might have an adverse effect on competition, are also forbidden. The Department of Justice (DOJ) and Federal Trade Commission (FTC), as well as private persons and companies which have been economically injured as a result of an antitrust violation, can bring legal actions to enforce the antitrust laws. The health care market has been subjected to antitrust scrutiny since the mid-1970's. Under the laws as they stand, groups of health providers may not legally agree on fee levels among themselves.

Even though the exemption proposed by section 1322 of the HSA could possibly benefit CNMs by permitting us to negotiate with the alliances over fees, we continue our opposition to such special interest legislation. ACNM has adopted this position because we believe that antitrust exemptions are contrary to the spirit and principles of health care reform

and harmful to consumer welfare. We also believe that all anticompetitive activities, whether monopolistic practices, competitor collusion, or discrimination by physicians, hospitals, and health plans against CNMs, will restrict optimal delivery of health care services, limit consumer choice and, ultimately, injure those who provide, as well as those who purchase, such services.

Relationship to Antitrust Guidelines. The summary of the Administration's Plan, which became public in September, proposed that guidelines would be developed by the DOJ and FTC to assist health care providers and health plans to determine whether their conduct might subject them to possible antitrust enforcement. For example, the development of network joint ventures by providers might involve fee-setting or limitation of the size of the panel, yet the overall purpose and effect of the venture to deliver managed health care services might be procompetitive. Such guidelines could help determine whether the activity would be subjected to antitrust scrutiny. The first such set of guidelines, entitled "Statements of Antitrust Enforcement Policy in the Health Care Area", was published by DOJ/FTC on September 15, 1993. ACNM has some concerns about these Statements, such as whether they will be equally applied to all health professionals and whether, in their emphasis upon price fixing, the

Statements fail to address exclusion of competitors as a potential violation.¹ They are, however, based upon existing law and, by providing guidance, eliminate any need for an overall exemption.

In early October 1993, the AMA wrote to the antitrust agencies, expressing dissatisfaction with most aspects of the Statements, and renewing its demand for an antitrust exemption which would permit groups of physicians, even when acting through state medical societies, to negotiate directly over fees, as well as other terms and conditions of payment and coverage. The AMA's request appears to have been addressed by section 1322 (c) of the HSA.

The term "negotiations" is defined, in subsection (c)(7), broadly enough to encompass and shelter every type of price fixing activity imaginable. The permitted range of negotiations will provide an opportunity for unparalleled competitor collusion on fees, collusion which is highly likely to spill over into and taint areas where such competitor price fixing is not permitted, such as network negotiations with health plans. Allowing competitors to exchange fee information and to develop consensus on the fees which will be sought from the alliances can only have the inevitable effect of increasing the risk that this information will be used in other, still-

¹ In a speech to the American Society of Association Executives on October 22, 1993, the Acting Director of the Bureau of Competition of the Federal Trade Commission, Mary Lou Steptoe, Esq., indicated that the Statements apply equally to members of all professional and trade associations. 65 Antitrust and Trade Regulation Report 551 (BNA) (October 22, 1993).

prohibited contexts. This process might result, for example, in bid-rigging rather than a competitive bidding process for selection of qualified health plans by the alliances.² For all these reasons, ACNM opposes any antitrust exemption as an aspect of health care reform and urges that an alternative method of developing a fee schedule be substituted.

OTHER CONSUMER CONCERNS

ACNM has concerns that the "undocumented" immigrant population has not been included in the reform proposal. Our code of ethics prohibits us from discrimination based on race, religion, lifestyle, sexual orientation, socio-economic status or the nature of the problem.

We also have some concerns around the treatment of family planning services. The mandated benefit package in the plan includes "family planning services" as covered services. Despite the fact that many of these services are preventive, they are not considered preventive for the purposes of the legislation. As a result, with the exception of prenatal and postpartum care, family planning services are subject to deductibles and cost-sharing requirements.

These cost-sharing requirements would be waived entirely for individuals eligible with Aid to Families with Dependent Children (AFDC, or

² The broad scope of this definition creates at least a potential inconsistency between this section and a number of the Enforcement Statements, which specifically prohibit most exchanges of fee information among provider group members except under very limited circumstances.

welfare) and reduced for families with incomes below 150% of poverty. All other individuals would be required to meet them. While a five or ten dollar copayment per office visit may seem reasonable to us, for many women this will impose a hardship - the choice of paying the rent or putting food on the table.

An added problem is posed by the definition - or lack thereof - of "family planning services." For example, the definition includes medical devices but not drugs, such as oral contraceptives.

Sexually transmitted diseases are not totally covered by the HSA. The legislation refers to "fertility related infectious illness." This is not a term commonly used in the industry today. The preventive package would include annual screening for gonorrhea and chlamydia for women who have reached childbearing age and who are at risk of fertility related illness. However, it does not include other STDs, such as syphilis, that could not be considered "fertility related."

A third area in which the bill's promise of preventive care falls short is in its coverage of maternity care. While prenatal and postpartum care are not considered preventive services "per se" under the bill, they are nonetheless exempt from any cost-sharing that would otherwise be required. Pregnant women who are currently entitled to free prenatal care under Medicaid would be required to pay a share of their premiums if their income was above 150% of poverty. This would be a step backwards. Currently, about half the states completely subsidize this coverage up to 185% of the poverty level.

CONCLUSION

On behalf of the American College of Nurse-Midwives, I would be pleased to answer any questions, or provide additional information. We look forward to working with you on health care reform.

Mr. WAXMAN. Dr. Ebert.

STATEMENT OF PAUL A. EBERT

Mr. EBERT. Pleasure for the American College of Surgeons to be able to comment, and congratulate you and Senator Rockefeller on your proposed legislation on graduate medical education. It is a problem and a question that has been around a long time. We do have, I am sure, some disagreements on small segments regarding geographic components of it. I would like to make a few general comments.

The college supported and I think originally proposed the position that the total number of medical and surgical resident positions in the country be calculated. We supported the efforts of COGME and felt in many ways they have done a good job, and what we really needed was an effective arm to take some of their recommendations forward. So we did not mind the broad limits being placed on residents whether surgical specialties, medical specialties, primary care, et cetera.

We do take, have taken an interest along the way for the policy-makers to move effectively and meet the primary care needs of all Americans. We think there is no question that this is a very important issue.

We are a little concerned that possibly the definition of "primary care" may be just a little too simplistic. It certainly makes a difference in rural America; also in some of the urban areas where there is definitely a crossover. We prefer a definition something of primary care that is really the initial valuation and treatment provided to a patient for a disorder or a condition essentially irrespective of the physician's training or specialty designation.

I think for information that is of interest, in 1980, 21 percent of the total number of residents—that total number of students graduated in surgical specialties, and by 1992 that percentage has decreased to 24 percent. We do not know whether the correct number of so-called "primary care residents" should be 50 percent, 55 percent, whatever, but we do support the concept that externally there should be some commission or group that could make recommendations regarding how this particular number—I know Congress has considered many proposals in an attempt to influence the mix of medical and surgical specialists.

Many of these have given the concept that the primary care residents might get a higher reimbursement or incentives to go into residency. We do not think this is really necessary and that if someone actually made an attempt to determine, and we recognize there are errors in any group that does try to make these recommendations, but at least it is a start, that it is very important that all specialties that are at least agreed upon to be the correct mix be funded through the entire length of the training. Because even though the country may believe it needs more primary care specialists, I think it also has to recognize it probably needs well-trained, well-qualified specialists in most medical, surgical, radiological, and other various specialties.

We do disagree with some of the proposal only dealing with the geographic component. We believe you would be better to put this on a national basis. We think the mechanism that is in place be-

tween the ACGME, as well as the residency review committees, could easily qualify and grade a program. We recognize there may be some discrepancies.

You may have too many good programs in Los Angeles and not enough in San Francisco or something like that, but I think these could be worked out even if you categorized them in quarters or something of that nature so that there were a top 25, lower 25.

We realize this probably would require time and we recognize also that it is pretty much impossible to do specialty differentials, so to speak, until someone deals with the number of total residency slots in the United States. Because if they were done without dealing with the total number, one would probably not end up with a mix that is much different than what we have today.

So we applaud you on your efforts and we certainly support the concept. We would be very happy to participate in any way possible to come up with reasonable numbers. Thank you.

Mr. WAXMAN. Thank you very much. We look forward to working with you on it.

[The prepared statement of Mr. Ebert follows:]

STATEMENT
of the
AMERICAN COLLEGE OF SURGEONS

to the
Subcommittee on Health and the Environment
Committee on Energy and Commerce
U.S. House of Representatives

presented by

Paul A. Ebert, MD, FACS

**RE: Physician Workforce/Graduate Medical Education Financing
and Health System Reform**

January 25, 1994

Mr. Chairman and members of the Subcommittee, I am Paul A. Ebert, MD, FACS, Director of the American College of Surgeons. I am pleased to appear here today on behalf of the College to provide our views on some of the proposals Congress is considering to shape the number and the specialty mix of physicians being trained by our nation's graduate medical education system. I would also like to offer a few observations about how one category of essential providers -- trauma care systems -- may be affected by a managed competition approach to health system reform.

First of all, I want to note that the College agrees with many aspects of the physician workforce control strategy and the graduate medical education financing policies proposed in the President's Health Security Act. We agree that a limit should be placed on the total number of physicians to be trained, and the proposed limit of 110 percent of U.S. medical

school graduates appears reasonable. We also agree that broad goals should be set regarding the number of generalists and specialists to be trained. A ratio of 50:50 generalists to specialists, or even a 55:45 ratio, seems reasonable (although perhaps not quite feasible in the short time frame being proposed). In fact, the College has proposed the concept of limits on the number and the specialty mix of physicians on several occasions in the past two years, both in testimony before Congress and in meetings with Administration officials. We also support the concept of establishing a single, consolidated financing pool for graduate medical education.

The College believes very strongly, however, that quality should be the major factor in determining which residency training programs should be funded and how actual residency slots will be allocated. Other factors identified in the Health Security Act, such as geographic need and minority participation, are important and worthy of consideration, all things being equal, but our nation's finest physician training programs must be preserved.

We suggest that the Residency Review Committees (RRCs) might be given the responsibility of ranking the existing residency training programs on the basis of quality. While we recognize that making such determinations would be difficult, we believe the RRCs could accomplish this at least in broad terms -- perhaps by establishing quarterly percentile categories (e.g., top 25 percent, second 25 percent, and so on). The RRCs could then submit this data to an independent board or commission, which would have the responsibility of actually determining which programs would be eliminated or reduced in

size, taking into account other important factors such as geographic need and minority participation. Such a strategy would not only assure that our graduate medical education system remains the finest in the world, but it would also serve a second and worthy goal of raising the overall quality of physician training throughout the nation.

In the surgical specialties, the number of individuals being trained has been restrained by such quality considerations for many years. No surgical training program can add new residency positions unless patient mix and volume assure that specific training criteria are met. This limits both the number and the size of surgical training programs. In addition, smaller training programs with relatively few residents are held to the same high standards as larger programs.

It has been suggested that across-the-board reductions in residency positions could be implemented to reduce the overall supply of physicians or the number of physicians trained in certain specialties. The College opposes such an approach. In some surgical specialties, the number being trained each year is actually quite small, and the number of residents in any one training program can be very small. In pediatric surgery, for example, only about 40 individuals are trained each year throughout the nation. Imposing an across-the-board reduction in residency positions in such specialties would have a devastating impact on some excellent and very important training programs.

In the past, Congress has made some effort to limit the number of specialists being

trained by reducing Medicare's financial support for those specialties with longer residency periods. Some workforce proposals would carry this policy even further. In fact, the Managed Competition Act would limit graduate medical education financing to four years, in addition to implementing specialty training limits like those proposed in the President's plan.

Frankly, the College has always doubted the theory that program financing is likely to influence an individual medical student's career choice. Further, implementing such a policy in addition to a strategy that places absolute limits on the number of training positions available in the various specialties makes this option irrelevant, and would likely hamper our nation's ability to meet all of its physician workforce needs.

While we understand the interest in Congress to meet certain primary care goals, our nation needs an adequate mix of both generalists and specialists to provide the care its citizens require. Those specialties with the longest training periods -- such as neurosurgery, which typically includes seven years of residency training -- are just as critical to the health care needs of our nation as those with the shortest residency training. Under a strategy where a government appointed council determines what it believes to be an accurate estimate of the number of generalists and specialists that should be trained, the notion of further attempting to discourage individuals from entering specialties with longer residency periods is pointless.

Further, it is important to keep in mind that some specialties other than primary care have been identified as likely to face future workforce shortages. For example, the Council on Graduate Medical Education and others have expressed concern that the number of general surgeons being trained may not be adequate to meet the health care needs of our aging population. Indeed, general surgery (which has a five to six year residency period) faces many of the same problems as internal medicine in that many individuals who complete their training in the specialty go on to further training in a subspecialty field.

For all these reasons, the College can not support any physician workforce control strategy that does not assure adequate and full financing for all physician training programs, regardless of specialty.

I would also note that some features of the Medicare payment reductions being proposed in the Health Security Act seem incongruous with the plan's physician workforce goals and graduate medical education financing policies. For example, the proposal to limit payment for services provided in high cost tertiary care centers threatens the financial viability of institutions that administer many of our nation's finest physician training programs. We recommend that Congress avoid implementing such policies, at least until a comprehensive workforce strategy is implemented and the likely impact on our graduate medical education system is fully assessed.

Under the Health Security Act, a significant source of funding for graduate medical

education programs is expected to come from health and corporate alliances. In the event that Congress elects to adopt a different structural approach to health care reform, we would urge you to consider the impact that approach might have on the availability and adequacy of financial support for the graduate medical education objectives set forth in the President's plan.

Finally, I would like to offer a few comments regarding the National Council on Graduate Medical Education that would be established under the Health Security Act to set limits on the number of individuals that will be trained in the various specialties. Congress should be certain that there is adequate representation of physician specialties on this council. To use trauma care as an example, this council should certainly include an individual who understands the trends and needs of this nation in training surgeons to provide these essential services.

We understand, of course, that there may be a reluctance to include representatives of each and every specialty and subspecialty on this council; to do so could make it unwieldy and ineffective. But, it should be possible to create a reasonably sized body whose make up assures broad experience and knowledge of the major categories of disease. Further, we recommend that Congress provide explicit instructions that would require the council to solicit input from those specialties that are not directly represented by its membership.

Health Reform and Trauma Care Systems

We are pleased that the Subcommittee has chosen to include a panel at this hearing on essential providers, and that trauma care systems are being considered in this category. Because the College is deeply committed to improving the quality of care available to trauma victims, I would like to take a few moments to express some concerns about the continued access to quality trauma care services and the further development of trauma care systems under a managed competition approach to health system reform.

Of course, there is no question that trauma care services would be covered under the benefits package being proposed in the President's Health Security Act, as well as under the other major health care reform proposals being considered by Congress. Indeed, there are many aspects of the President's plan that appear to favor comprehensive trauma care systems. For example, the standard benefits package includes rehabilitation services, and the proposal recognizes that injuries and medical emergencies often occur when people are far from home. Standard data collection efforts, such as those conducted by state trauma registries, are encouraged.

The President also appears to support the concept of establishing networks and centers of excellence, recognizing that not all diseases can be most effectively nor most efficiently treated in all facilities. The requirement that all health plans contract with academic health centers for certain services would also seem to favor continued access to Level I trauma centers, which tend to be located in these institutions. Finally, the prospect

of all health care services being paid for under health system reform certainly seems to resolve one of the major factors threatening the viability of trauma care systems today -- uncompensated care -- even if the level of reimbursement for these complex services is not yet clear.

However, we do have serious concerns about how trauma care systems will be permitted to operate under an approach to health care reform that appears to rely so heavily on managed care with exclusive provider networks. For example, trauma care in smaller communities and in rural areas is provided by non-academic health centers -- classified in the College's guidelines as Level II, Level III, and Level IV trauma centers. As currently written, the Health Security Act does not require health plans to contract with these facilities to provide specialized trauma care services in areas where trauma systems are currently in operation. Therefore, a severely injured individual whose health plan network does not include the local trauma center could very well be denied access to a vital health care resource. In addition, closed health plan networks could pose barriers to the development of new trauma care systems in areas where they do not yet exist.

It is important to note that managed care networks and trauma care systems can and do work well together in many areas. In San Diego county, for example, a detailed and very satisfactory cooperative agreement has been reached between the trauma care system and the local Kaiser plan. The trauma surgeon in the designated trauma center retains responsibility for managing the care of severely injured Kaiser patients and, in turn, agrees

to transfer patients to the Kaiser hospital if it is medically appropriate. Unfortunately, there is anecdotal evidence that such close cooperation for the benefit of injured patients is not the norm in some communities.

Congress, and this Committee in particular, have invested considerable effort in promoting the development of trauma care systems and in preserving those that have already been established. These systems of care are the primary mechanism for addressing one of the nation's major public health problems, and they must be preserved and encouraged. Therefore, we urge you to include provisions in your health system reform package that would require all health plans to establish contracts with designated trauma care centers to provide care for severely injured patients.

Conclusion

Once again, I appreciate this opportunity to present the College's views on these issues, and I would be happy to answer any questions you may have.

Mr. WAXMAN. Dr. Jacott.

STATEMENT OF WILLIAM E. JACOTT

Mr. JACOTT. Thank you, Mr. Chairman. My name is William Jacott. In addition to what you said, as Assistant Vice President at the University of Minnesota in the Academic Health Center, I am also a family physician, and Vice Chair of the AMA Board of Trustees. On behalf of the AMA, I am pleased to have this opportunity to testify on these important issues.

Graduate medical education and work force planning issues are of utmost concern to the AMA, including our many resident physician and medical student members. We feel that positive incentives should be employed to increase the number of primary care, minority, and rural physicians.

The AMA supports establishing a national priority and appropriate funding for increased training of primary care physicians. However, we believe that work force planning should be based on physician-to-population ratio data, not specialty mix percentages like 50-50 or 55-45.

In addition, work force planning must also take into account such other factors as regional variations, differences in practice style based on physicians' length of time in practice, gender-based practice differences, and utilization by certain practice models.

The AMA believes that freedom of choice for medical students in choosing a specialty and career in medicine, as for anyone else in any other profession, must be maintained. We do not support establishing a fixed ratio of primary care to nonprimary care physicians.

The AMA supports an incentive-directed, private sector initiative for work force planning, and towards that end we recommend a work force commission, composed predominantly of both academic and community physicians, to study and develop recommendations on physician work force issues and to advise the Secretary of HHS on all issues related to the physician work force planning.

In determining appropriate numbers and types of physicians, regional differences and needs must be carefully considered, particularly in medically underserved areas, and it is inappropriate to use the residency accreditation process to make workforce decisions.

We support uniform participation by all payers in the financing of graduate medical education. Funds for graduate medical education should be allocated based on regional needs.

The AMA recognizes and appreciates the unique role and mission that our various academic health centers fulfill and supports the concept that Federal assistance in fulfilling this role is essential. In doing this, we believe that the definition of entities that should be eligible to receive such funding should be those entities operating teaching hospitals with accredited medical or osteopathic resident physician training programs and having some affiliation or association with an accredited medical or osteopathic school.

The AMA supports appropriate collaboration among physicians and other health professionals within the scope of their education and training to achieve the best results for patient care. Determinations of appropriate collaboration should be mutually developed through interdisciplinary discussions.

Specifically we recommend national studies to identify those programs where physicians, nurses, and other health professionals have been working on a collaborative basis. And recently, Mr. Chairman, we met with the American Nurses Association at our invitation earlier this month to talk about collaboration and talk about scope of practice issues. We have agreed to form a task force consisting of leadership from both those organizations, and we are going to begin a series of meetings to continue that discussion.

The Nation's physicians are committed to expanding access to the underserved. The AMA's concern led us nearly five years ago to develop Health Access America, a proposal to reform the Nation's health care system and achieve universal coverage.

Our commitment to universal coverage underscores our recognition that a team approach to health care is one way we can enhance working together with nurses and other health professionals throughout the process of reform to provide needed health promotion and preventive services.

The AMA supports the proactive rural and underserved urban health care reform agenda set forth in H.R. 3600. We are pleased to have had this opportunity to testify here today and we look forward to working together with you in the future.

Mr. WAXMAN. Thank you very much, Dr. Jacott.

[Testimony resumes on p. 513.]

[The prepared statement of Dr. Jacott follows:]

STATEMENT
of the
AMERICAN MEDICAL ASSOCIATION
to the
Subcommittee on Health and the Environment
Committee on Energy and Commerce
U.S. House of Representatives
Presented by William E. Jacott, MD
RE: Physician Workforce and Related Issues
January 25, 1994

Mr. Chairman and Members of the Subcommittee:

My name is William E. Jacott, MD. I am a family physician, Assistant Vice President for Health Sciences at the University of Minnesota, and Vice-Chair of the Board of Trustees of the American Medical Association (AMA). Accompanying me is Jeffery M. Stokols, Legislative Counsel in the AMA's Division of Federal Legislation. On behalf of the AMA, we are pleased to have this opportunity to testify regarding issues of physician workforce, including graduate medical education funding, academic health centers, scope of practice, and practice in underserved areas. These issues involve key elements of our nation's health care system and how they are addressed will have a major influence on how medical care is provided well into the future. Along with other issues related to universal health care coverage, they will have a profound impact on our nation.

Graduate medical education and workforce planning issues are of utmost concern to the AMA, including our many resident physician and medical student members. First and foremost, the AMA believes the profession should be centrally involved in addressing physician numbers, specialty mix

and geographic distribution. We have serious concerns about the potential effects of federally controlled workforce planning, particularly by the introduction of federal mandates into our private and state educational systems. At the same time, positive incentives should be employed to increase the number of primary care, minority, and rural physicians. These positive incentives should include attention to physician satisfaction with practice and practice locations, appropriate role models for physicians in training, lifestyle issues, loan forgiveness and other financial incentives, and physician reimbursement.

Increased Training of Primary Care Physicians

On the issue of attracting individuals to seek careers in primary care, the AMA supports establishing "a national priority and appropriate funding for increased training of primary care physicians."

However, we concur with the large number of workforce analysts who now agree that workforce planning should be based on physician-to-population ratio data, not specialty mix percentages such as 50/50 or 55/45. In addition, workforce planning must also take into account such other factors as regional variations, differences based on physicians' length of time in practice, gender-based practice differences, and utilization by certain practice models. For example, the experience of group and staff model HMOs in this country indicates utilization in the range of only 60 primary care physicians per 100,000 individuals.

Additionally, the AMA believes that freedom of choice for medical students in choosing a specialty and career in medicine, as for any one else in any other profession, must be maintained. Thus, we do not support granting the federal government nearly total control over graduate medical education by establishing a required ratio of primary care to nonprimary care physicians, as called for in H.R. 3600, the "Health Security Act," and in other bills.

While medical schools should be permitted to define their own missions, incentives should be created to further the production of primary care physicians. Schools should be encouraged to develop mentoring and other programs to encourage students to enter a primary care field, and they should monitor their graduates' ultimate specialty choices and practice locations, to assess the attainment of their stated missions.

The high cost of medical education, and the usually significant debt that medical students face at the time of their graduation, may influence specialty choice. Scholarship and loan repayment programs, already existing at the national and state levels, should be expanded in ways that will encourage their use. Qualified students from rural or other underserved areas and minority students should be especially recruited and supported, since experience shows that there is a greater likelihood for a student from such a background to return to the root (or a similar) community upon completion of medical training.

Support should be provided for medical schools to introduce or enhance educational programs that have been associated with the choice of a primary care career, such as family medicine clerkships, patient longitudinal primary care experiences, and preceptorships with practicing physicians. Primary care physicians should be more fully integrated into the medical school as teachers, as career advisors, and as members of key academic committees. The academic base of primary care physicians must be enhanced. One strategy which we support is to increase funding for research in primary care. This would enhance the scholarly activities of these disciplines and help establish the scientific stature of the primary care physician. It should be noted that the AMA now publishes a peer reviewed journal in family medicine.

A number of factors have been cited as influencing the choice of a primary care career. Strategies to enhance students' interest in primary care should be directed at a variety of targets, including the medical schools, the residency programs, those who finance health care, and the entire practice environment. We offer the following recommendations as avenues to attract individuals to seek careers in primary care:

The Medical School Experience

1. Each medical school should reexamine its institutional goals and objectives, including the extent of its commitment to primary care. Those schools recognizing a commitment related to primary care should make this an explicit part of the mission, and set institutional priorities accordingly.
2. The admission process should be sensitive to the institution's mission. Those schools with missions that include primary care should consider those predictor variables known to be associated with choice of these specialties.
3. Through early recruitment and outreach activities, attempts should be made to increase the pool of applicants likely to practice primary care.
4. Carefully considered financial incentive and support programs should be developed to encourage students to select and practice primary care. Financing mechanisms that selectively limit student specialty choice should be avoided.
5. Medical schools with an explicit commitment to primary care should structure the curriculum to support this objective.
6. All four years of the curriculum in every medical school should provide experiences in primary care for all students. These experiences should feature increasing levels of student responsibility and use of ambulatory and community settings.
7. The visibility of primary care faculty members should be enhanced within the medical school and positive attitudes toward primary care among all faculty members should be encouraged.
8. Medical schools should provide career counseling related to the choice of a primary care specialty.

The Residency Curriculum

9. The curriculum in primary care residency programs and the sites used for training should be consistent with the objective of primary care physicians.

The Practice Environment

10. There should be increased financial incentives for physicians practicing primary care. As long as there are significant differences in financial rewards between primary and specialist caregivers, there will be difficulty attracting and maintaining the number of generalists which the nation requires.
11. Administrative support mechanisms should be developed to assist primary care physicians in the logistics of their practices, and enhanced efforts to eliminate "hassle" and unnecessary paper work should be undertaken.
12. There should be educational support systems for primary care physicians, especially those practicing in underserved areas.

External Mandates Directed at Medical Schools and Medical Students

13. States should be encouraged to provide positive incentives--such as scholarship or loan-repayment programs, relief of professional liability burdens and reduction of duplicative administrative responsibilities--to support medical students' choice of a primary care specialty. The imposition of specific outcome targets should be resisted, especially in the absence of additional support of the schools.

While we recommend a number of different strategies to increase the number of primary care physicians, it is important to recognize that for any action to have a significant chance of success, it must be part of a series of comprehensive actions that address matters such as education, health care financing, and the practice environment. In addition, any "solution" must involve a partnership effort between the federal government, medical schools, the medical profession and the community.

Other Physician Workforce Issues

The AMA supports an incentive-directed, private sector initiative for workforce planning. Toward that end, the AMA recommends a workforce commission, composed predominantly of both academic and community physicians, to study and develop recommendations on physician workforce issues. This commission would advise the Secretary of Health and Human Services on all issues related to physician workforce planning. Antitrust relief is needed to allow appropriate professional input into

issues of physician workforce planning, particularly in dealing with total numbers of physicians and the mix of generalists to specialists.

The AMA has taken positions regarding some other ideas relating to physician workforce issues that have surfaced in various proposals. In determining appropriate numbers and types of physicians, regional differences and needs must be carefully considered, particularly in medically underserved areas. This is particularly true if there were to be a reduction in the total number of entry positions in approved U.S. medical residency training programs, as was suggested in a number of legislative proposals introduced last year. The AMA also opposes using the residency accreditation process to make workforce decisions (for example, ranking residency programs according to quality and using such rankings to allocate residency positions among programs). The AMA does not believe that "weighting" of residency positions toward primary care would have a significant effect on specialty choice.

On the issue of retraining other specialist physicians to provide primary care, the AMA believes that many physicians who are not in what are commonly considered primary care specialties already provide some primary care services and that many others could, perhaps, do so, given appropriate retraining. The need for such retraining should be determined and evaluated. Thus, we support data gathering and pilot programs to determine the value of specific retraining programs.

Finally, the AMA supports increased federal funding for expansion of the National Health Service Corps to meet access needs in truly underserved areas, as well as the possible use of those sites for experiences in primary care training, with support for teams of physicians and other health professionals working in a supervised, collaborative model, with tax preferences and increased

reimbursement as appropriate incentives. We do not support singling out health care professionals for compulsory national service.

Graduate Medical Education Financing

We support uniform participation by all payors in the financing of graduate medical education and the elimination of unwarranted variation among hospitals in graduate medical education costs claimed.

The AMA continues to support an all payor plan.

Funds for graduate medical education should be allocated based on regional needs, utilizing regional consortia with medical school involvement. Direct residency funding should include the costs of faculty supervision and other related teaching expenses. HCFA regulations should be modified sufficiently to minimize the vast differences in direct residency reimbursement that have existed in the past, but should not be based on a national average, which could unduly penalize institutions in certain regions while unjustly rewarding others.

In the current practice environment, increasing amounts of health care are being delivered to the citizens of this nation in ambulatory settings. Graduate and undergraduate medical education in ambulatory and primary care settings must be increased, although the proper education of all physicians will still require in-hospital based educational experiences. Determination of the proper balance of ambulatory and hospital-based education of physicians should be done by the nation's medical schools. It is the responsibility of the Liaison Committee on Medical Education to establish standards for medical student education and of the Accreditation Council on Graduate Medical Education and the appropriate residency review committees (RRCs) to establish the standards for

graduate medical education (medical residency training). If more ambulatory training is to be conducted, funding must be provided for this activity.

In the current financing mechanism and in those proposed, there are insufficient funds to provide for such training in a cost-conscious environment. As regards funding to encourage more ambulatory and community based education on the part of medical schools and residency programs, one obvious source of such funding is the present Medicare indirect graduate medical education payments. Therefore, revising the current Medicare indirect medical education formula should take into account the need to support education in ambulatory and community sites. Finally, a mechanism for proper transition funding through the period of time necessary to fully implement an all payor system should be developed so that undue financial hardships are not created on teaching hospitals.

Academic Health Centers

The AMA recognizes and appreciates the unique role and mission that our various academic health centers fulfill and supports the concept that federal assistance in fulfilling this role is essential. In supporting federal funding for academic health centers, we feel strongly that the definition of entities that should be eligible to receive such funding should be limited to those entities operating teaching hospitals with accredited medical/osteopathic resident physician training programs and having some formal affiliation or association with an accredited medical/osteopathic school in this country. Only in this fashion will we be able to ensure that the true mission of the academic health center will be accomplished. Additionally, we support the provisions of H.R. 3600 which require that federal funding be used to assist academic health centers with costs related to their academic mission. These additional costs are related to: 1) the reduced rate of productivity of faculty due to teaching responsibilities; 2) the uncompensated costs of clinical research; and 3) exceptional costs associated

with the diagnosis and treatment of rare diseases, treatment of unusually severe conditions, and providing other specialized health care.

Scope of Practice

The AMA supports appropriate collaboration among physicians and other health professionals within the scope of their education and training to achieve the best results for patient care. Determinations of "appropriate" collaboration should be mutually-developed through interdisciplinary discussions.

Standards for determination of scope of practice for various health professionals should be established at the state level, including provisions that would preclude inappropriate restriction of practice by those professionals demonstrating educational and clinical competence.

Specifically, we recommend:

- National studies to identify those programs where physicians, nurses, and other health professionals have been working on a collaborative basis both successfully and unsuccessfully and the dissemination of such information broadly.
- These studies should also provide support for the interdisciplinary discussions on a mutually-acceptable definition of "collaborative practice" and for discussion of such issues as reimbursement for services and the identification of advance practice nursing roles in the hospital and community settings.

A number of team models are already in place throughout the country, providing satisfying results for patients, their family members and health care professionals. In Oklahoma, for example, visiting nurses now use telemedicine to work jointly with physicians to expand access to care in underserved areas. These nurses work with patients in their homes, assess their comprehensive treatment needs, take videos for physician review, and then continue to work with the physician managing the case to ensure that appropriate care plans are developed and followed. The AMA strongly supports use of

interdisciplinary models as ways to achieve better continuity and broader access to high quality patient care.

We recently met with representatives of the American Nurses Association (ANA) to discuss scope of practice issues and collaboration. We have identified a small task force of AMA and ANA leadership to continue these discussions. These team programs will require a nationally recognized definition of collaboration, one example of which is in existing federal law, contained in Section 1861(aa)(4)(6) of the Medicare statute (the Rural Health Clinic Services and Federally Qualified Health Center Services Act, 42 U.S.C. Section 1395x(aa)). This language defines "collaboration" as "a process in which a nurse practitioner works with a physician to deliver health care services within the scope of the practitioner's professional expertise, with medical direction and appropriate supervision, as provided for in jointly developed guidelines or other mechanisms as defined by the law of the State."

The nation's physicians are committed to expanding access to the underserved. The AMA's concern led us nearly five years ago to develop Health Access America, a proposal to reform the nation's health care system and achieve universal coverage through changes in insurance and alternative financing mechanisms. Our commitment to universal coverage underscores our recognition that a team approach to health care is one way we can continue to and enhance working together with nurses and other health professionals throughout the process of reform to provide needed health and preventive care to everyone who needs it.

Underserved Areas

The AMA supports the pro-active rural and underserved urban health care reform agenda set forth in H.R. 3600. Its provision of public health funds for "core functions" to target violence, environmental

hazards and toxins, infectious diseases, education on prevention strategies, and education on appropriate use of medical services will aid rural, as well as poor urban communities, many of which have disproportionately high numbers of patients who receive Medicare or Medicaid, or are uninsured. H.R. 3600 will also provide grants to physicians and health clinics as "qualified community networks" to provide the federal benefits package to significant numbers of underserved populations. Furthermore, H.R. 3600 provides for favorable treatment of essential community providers, or those who serve a disproportionate number of poor clients, including a number of rural and urban hospitals. For at least a transitional period, H.R. 3600 would require all health plans to reimburse essential community providers at the same rate as other providers or based on Medicare principles. H.R. 3600 also provides tax credits for physicians, nurse practitioners and physician assistants. H.R. 3600 would also allow physicians serving in the National Health Services Corps to exclude loan paybacks from income, allow medical student loan interest deduction of up to \$5,000 per year, and permit a \$10,000 a year tax allowance for equipment purchased in Health Professional Shortage Areas (HPSAs). The AMA has long supported these kinds of programs in rural and underserved urban areas, and we strongly support these aspects of the bill. Further, we believe that perhaps even greater assistance needs to be extended to health care providers in underserved areas. Assistance to help such providers to develop their own networks is critical. We support this component of H.R. 3600.

Besides the new approaches sought by H.R. 3600, existing successful programs should also be continued and enhanced. The AMA supports continuation of the Rural Health Clinics and Federally Qualified Health Centers programs, as well as other federal and state policies aimed at preserving the viability of hospitals and physician practices in underserved areas. We support the use of skilled and appropriately trained non-physician practitioners, working together with physicians, to improve access

to care. Further, we support voluntary educational and economic strategies to increase physician practice in rural and urban areas.

We also support H.R. 3600's health system reform that focuses on increasing access to patients through better links with existing health care systems and the expanded insurance coverage that will be available through regional health alliances. We commend H.R. 3600's vision in providing relief to the majority of rural insurance subscribers and the many others who are self-employed, work for small businesses, or are unemployed or underemployed, who now pay exorbitant fees for health coverage or must go uninsured because coverage is unaffordable for single and small group subscribers. The AMA strongly supports H.R. 3600's goal of ending this inequity. We view it as a most crucial aspect of any health system reform which may ultimately be enacted in this country.

Physicians, not corporations, must maintain responsibility for making medical decisions in the context of the patient-physician relationship. Any successful health reform plan must take into account the special needs of rural populations to ensure that treatment approaches and reimbursement take into consideration a generally older and poorer rural population. The preservation of fee-for-service medicine that H.R. 3600 provides for will be especially critical to this vulnerable population. Special incentives and networks to support fee-for-service medicine must remain at the heart of rural health care in order to maintain access to, continuity of, and quality of care.

Conclusion

Again, we are pleased to have had this opportunity to testify regarding issues of physician workforce, graduate medical education funding, academic health centers, scope of practice, and practice in underserved areas. We look forward to working together further in the future with this Subcommittee, the full Energy and Commerce Committee, the President and the entire Congress on all of these issues, as well as other issues related to the vital aspects of health system reform. We hope that, together, we can achieve our common objective of assuring access to high quality and affordable health care to all of our citizens.

Mr. WAXMAN. Ms. Bash, your testimony documents a significant gap in the number of certified nurse midwives needed by the year 2000 in contrast to the number in practice today. Dr. Towers, you also estimate that by the year 2000 we will need some 37,000 new primary care practitioners.

Obviously new funds are required to start new education programs and to expand existing ones. As you know, the Health Security Act creates a new and targeted educational fund similar to the model for financing physician residency training.

In your opinion, will it still be necessary to continue support for midwifery programs and for advanced practice nursing programs under title VIII of the Public Health Service Act which are also designed to establish or expand such educational programs?

Ms. BASH. I believe that it might—we will constantly need money and there is—

Mr. WAXMAN. Is your mike on, by the way?

Ms. BASH. It is not, okay. I believe we will constantly need those additional funds. True, at this point, we are looking at 10,000 certified nurse midwives by the year 2001.

Presently, we have approximately 800 nurse midwives entering and involved in a nurse midwifery programs throughout the country on an annual basis, based on last year's figures. But these fundings will be needed because of the long period of time that it takes, because we are taking—the majority of our students are women, although we do have men in our programs.

We are taking them out of the already existing work force. Their living conditions and the cost of education is quite expensive and I think they will need all the funds that we can give them.

Mr. WAXMAN. Thank you.

Ms. TOWERS. A lot will depend on how that additional funding is established and how it is utilized. Right now the traditional way those kinds of funds are used through GME would not cover many of the things that are currently covered through the title VIII framework, which calls for monies to help programs start up, calls for monies to help look at workforce analysis, and that sort of thing which are not in—would not be in those other things, so at this point in time, the way those are divided, it would not seem appropriate that one would discontinue while the other started up.

Mr. WAXMAN. Dr. Jacott, Ms. Bash has expressed concern over what she views as barriers in the health marketplace preventing certified nurse midwives from providing services within the full scope of their license. She cites major obstacles like the refusal of health plans to reimburse for CNM services or to permit CNM's to join provider networks or the refusal of hospitals to grant practice privileges.

I wonder whether you think her concerns are justified, and should hospitals be required to offer CNM's independent admitting privileges within the scope of their license, and should qualified health plans, under the Health Security Act, be prohibited from denying reimbursement or participating provider status to CNM's?

Mr. JACOTT. The University of Minnesota has had a program in nurse midwifery for some time, and we respect the curriculum, and we respect the profession, and we appreciate the opportunity to work with them in our setting.

The issue of whether people are admitted to HMO's, PPOs and those kinds of organizations, sort of an any willing provider issue, is one that we are wrestling with, not only with other health professionals, but also with our own physicians with regard to closed panel HMO's and the ability of physicians to participate.

I think that is a very important issue for all health professionals in dealing with the various entities that are out there in the managed care arena.

As far as hospital privileges are concerned, I think that is, again, a hospital issue and an issue that some of the accreditors of hospital and some of those who establish the criteria for hospital privileges within each setting—a lot of the scope of practice issues are at each State level, and so that each State is establishing their own criteria.

The hospitals, I know our hospital, the nurse midwives, in collaboration with our physicians, are admitting patients and doing a great share of our deliveries.

Mr. WAXMAN. I guess the question is, if, within a State's scope of license, we have CNM's performing these different tasks, should we prevent discrimination against them by hospitals, by health plans? Should we do something affirmatively to protect them against discrimination that they feel they are subjected to?

Mr. JACOTT. I think if there is true discrimination, that should not exist. I think if hospital privileges are based on credentials and on clinical skills and on education, just as they should be for all practitioners, that is the kind of standard that we need to follow.

Mr. WAXMAN. Dr. Ebert, I couldn't help but notice the contrast between the college's support for the administration's approach to achieving a better mix of specialists and generalists and that of the AMA.

You have endorsed the proposed overall limits on the number of approved residency positions as well as the move to increase the number of primary care physicians to at least 50 percent of the total trained, and you have expressed support for the establishment of a national council working with the existing accrediting and certifying the bodies to carry out this policy.

How is it that the college has been able to develop a consensus on these issues within your broad membership, a membership that some might argue is most negatively affected by these policy changes, while the AMA has clearly expressed concern and opposition to what they describe as federally controlled workforce planning, particularly by the introduction of Federal mandates into our private and State educational systems?

Do you have any thoughts on that issue?

Mr. EBERT. About two or three. I must say, I didn't realize we would be quite as much in total opposition on the issue, but I guess this isn't the first time, so I am pretty used to this.

First of all, I think it is wrong to believe that medical students, one, have a—are denied a freedom of choice. There are more applicants to medical school than there are medical school positions. So already some type of selectivity goes forth.

The number of physicians in surgical residencies essentially hasn't changed in the last 20 years, and those are predominantly 100 percent filled, almost every year. Consequently, there is some

selection process that goes in there and there are individuals that wish to go into something that do not.

We have been through the route of financial stimulation, so to speak, to try to entice people and I think that is under false pretense. Why should you pay someone more to do the same job simply to direct them in something? I don't understand that particular belief.

The Federal Government is paying the majority of medical education costs at the present time, and we just simply believe in that setting it is not irrelevant that you would have an interest in the distribution of where these went.

I think the biggest issue in medical education is not the specialty differential issue. The big issue is whether or not the reduction of total residency positions in the United States could be reduced to some acceptable number. There are many unfilled residencies out there in many of the areas that we are trying to financially entice people to go into, probably more residencies than we need, and we think could go by—we think you thought something about it when you formed COGME and asked for a report.

We think they have done a pretty good job, but no one has ever been able to effect so to speak. The effective arm is not in place.

Mr. WAXMAN. Mr. Jacott, you want to respond to this instructive and enlightened position?

Mr. JACOTT. Thank you very much. Yes, there clearly are a lot of other incentives involved, and not just financial incentives, with regard to people choosing primary care or family practice.

I have participated for years at the University of Minnesota, which you heard Dr. Lee refer to this morning, for our family practice program, and we have a lot of incentives in our selection process, how we admit students, early and frequent exposure to the appropriate role models.

Those are all extremely important issues, and then as far as identifying practice style, there is a lot of things that need to be looked at regionally or locally that have to do with some of the issues that I mentioned that affect people's decision with regard to specialty and with regard to location.

Mr. WAXMAN. Thank you very much. I want to thank you all for your participation in this hearing. I think it has been very helpful. We appreciate your being with us.

Our final panel today includes a number of experts on the challenges of providing health care in rural America. Sandra Bennett Bruce is President of Mercy Muskegon Community Health Care System in Muskegon, Mich. and Chair of the Board of Trustees of the Michigan Hospital Association.

Richard J. Morrissey is Director of the Office of Local and Rural Health Systems at the Kansas Department of Health and Environment. Dr. Garth Splinter is Director of the Health Sciences Center, Health Affairs and Rural Health Program and Assistant Commissioner for Health Care Reform of the Oklahoma State Health Department.

And Carol Miller, who is a member of the Board of Trustees of the National Rural Health Association.

I want to welcome you to our hearing today. Your statements will be in the record in full. We would like to ask each of you to limit the presentation to no more than five minutes.

Ms. Bruce, why don't we start with you.

STATEMENTS OF SANDRA BENNETT BRUCE, CHAIRMAN, BOARD OF TRUSTEES, MICHIGAN HOSPITAL ASSOCIATION; RICHARD MORRISSEY, DIRECTOR, OFFICE OF LOCAL AND RURAL HEALTH SYSTEMS, KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT; GARTH L. SPLINTER, DIRECTOR, HEALTH SCIENCES CENTER, OKLAHOMA STATE HEALTH DEPARTMENT; AND CAROL MILLER, TRUSTEE, NATIONAL RURAL HEALTH ASSOCIATION

Ms. BRUCE. My name is Sandra Bennett Bruce. I am a recovering hospital administrator. I say this because although I am Chair of the Board of Trustees of the Michigan Hospital Association, and as such, I represent the association's 185 member hospitals, the health of our communities today can no longer be focused on hospitals, or on any other one provider group or one aspect of health care.

Because health care today is rapidly and inappropriately moving to the business of health and no longer focused on illness, in order to prepare for this new emphasis, networks of providers, representing the complete continuum of care, including hospitals, physicians and others, are forming, called medical alliances, with community care networks and great integrated delivery systems, accountable health plans.

They are all part of a new challenge to no longer just cure the sick, but to begin to improve the health status of our citizens for healthier communities.

In my every day job, I am the President and CEO of the Muskegon Community Health Care System, an integrated health care delivery system, serving a six county region of western Michigan.

In order for my system and many others around Michigan and the country to meet the needs of our communities, there are several issues of concern that I would like to ask for your help with today. While the integrated delivery systems I have described are forming today, even without your legislation, and are beginning to address some of the problems in the delivery of health care, we do need some recognition from Congress that these delivery systems are indeed desirable, and we need a clear explanation of how the Federal agencies intend to enforce laws for these systems' activities.

As Mr. Bilirakis said what seems to me a long time ago; it may have only been a few hours, there must be some clarity in laws governing fraud and abuse, anti-competitiveness and tax exempt status.

We need incentives to the reforms of the areas of law just mentioned, as well as through the establishment of risk adjusted capitated payments for all of our citizens, including Medicare and all of the other Federal programs, and, yes indeed, we believe they can work in both rural and urban America.

This would begin to align incentives and encourage providers within networks to avoid unnecessary duplication of services and

to conserve health care resources by putting patients at the most appropriate point in the continuum.

Universal coverage, however, is the cornerstone of reform and until all citizens have appropriate access to care, we won't have true reform. Universal coverage can have far more reaching effects than I think we have discussed today.

Recently Gerald Miller, Director of the Michigan Department of Social Services, argued that reform of the welfare system is largely dependent on the development of new ways to ensure access to the health care system for the poor, and I quote, "Health care is the major barrier to welfare reform."

But as has been stated already several times today, merely possessing a health security card that says I am an American, I am entitled, doesn't ensure that access and we must recognize and address the problems of the lack of primary care providers and especially in the rural areas.

We need support for increasing access to primary care providers, and you will notice that I deliberately used the term provider rather than physician. We have to change our attitude that all medical care must be delivered by a physician. Attitudes are changing.

A cardiologist walked into my office last week, having returned from one of his meetings, wearing a big badge on his shoulder saying, Cardiologist, I will do primary care for food. So attitudes can indeed change.

Mid-level practitioners, as has been testified just a few moments ago, such as physician assistants and nurse practitioners and certified nurse midwives, can provide much of the primary care needed in this country and at a lower cost.

In Muskegon we developed a staff model, primary care network. One-third of that network is not physician based. This group serves rural, urban, Medicaid, insured and uninsured, but for all these patients, they provide the needed generally low cost preventive services that keep people healthy. They serve as gatekeepers to costlier services and indeed, as testified earlier, I can tell you from experience, 70 to 80 percent of the care provided by primary care physicians in our network is indeed also provided by those mid-level practitioners.

I hear the bell has gone off. I thank you for the opportunity to speak to you today. I will be pleased to answer your questions later.

Mr. WAXMAN. Thank you, very much.

[Testimony resumes on p. 537.]

[The prepared statement of Ms. Bruce follows:]

STATEMENT OF SANDRA BENNETT BRUCE

Good morning, Mr. Chairman and members of the subcommittee, I am Sandra Bennett Bruce, Chairman of the Board of Trustees of the Michigan Hospital Association and President/CEO of Mercy Muskegon Community Healthcare System, in Muskegon, Michigan. On behalf of MHA's 185 member hospitals, I am pleased to testify today on issues relevant to the health care reform debate.

During 1991 and 1992, in anticipation of the intense debate that would develop around health care reform at the state and national levels, MHA members engaged in a careful, extended self-examination that recognized the need to shift the focus of providing health care from managing illness to managing health. In 1992, MHA adopted a Health Policy Vision Statement that declared:

We are committed to improving the health status of Michigan residents. This will be achieved by ensuring that each resident is entitled to a basic set of essential health services, and by collaboration with all relevant community resources. These services shall be of high quality, be efficiently delivered, be cost effective so as not to be a barrier to access, be adequately financed through both public and private payments, and be uniformly administered so as to ensure maximum efficiency within the system.

It is from this vision and principles relating to entitlement, financing/administration, cost containment/accountability, and organization and delivery that we approach health care reform's

challenges.

As the number of hearings this subcommittee has, or plans to conduct on the complex and controversial subject of health care reform testifies, there are seemingly so many issues that one can easily lose count. Each of these issues represent an area of critical interest and concern to those who bring them to your subcommittee. Today, I would like to focus on several issues of concern to Michigan's hospitals and to share our particular perspectives.

I would like touch on two issues which may initially seem relatively unrelated but in fact are inter-connected. These issues are delivery problems of rural, and urban, under-served areas, and the adequacy of provisions supporting providers in organizing integrated delivery systems. I will also touch on issues of essential community providers and uncompensated care, which are directly related to both issues.

Delivery Problems in Under-Served Areas, Both Rural and Urban.

Philip Lee, MD, Department of Health and Human Services Assistant Secretary for Health recently estimated that 72 million Americans live in inner-city and rural areas with shortages of providers. In some areas, the only local sources of care are federally funded clinics or public hospitals, which frequently are overcrowded and

under-funded.

The simple fact is that there are problems delivering adequate health care in certain geographical areas of the United States. Numerous studies and reports have documented the challenges of delivering care to rural and inner-city America. No one disputes the problem. In fact, each of the major health care reform proposals now before Congress explicitly acknowledges these circumstances through provisions intended to, at least, address or, at best, resolve the problems. We don't need more studies to verify what we all know exists.

Rural Delivery Problems

Rural populations are unique in the extent of physical barriers that they may encounter when obtaining health care. Even in relatively well-populated rural areas, the lack of a public transportation system and the existence of few local providers to choose from can make it difficult for many rural residents to reach facilities where they can receive care. And persons living in low-density "frontier" counties - counties of six or fewer persons per square mile - can have geographic access problems of immense proportions.

Many rural areas have experienced chronic primary care physician shortages, shortages likely to be exacerbated by the retirement of the aging rural physician population. Sixty-seven percent of the 1,955 primary care health manpower shortage areas (HMSAs) are in rural areas.

The supply of primary care physicians is extremely low in rural areas with small populations (<10,000 population); there is only one primary care physician for 2,857 individuals, compared to the national physician-to-population average of one physician for 614 individuals. In small counties, 20 percent of physicians are over the age of 65.

The shortage of primary care services in rural areas has a particularly adverse effect on the elderly living in these areas because they have the greatest need for health services of any age group. The situation is compounded by the fact that rural areas have a higher proportion of elderly residents. Thirteen percent of rural residents are 65 years of age or older compared to 10.7 percent of urban residents.

Economic barriers prevent many rural (as well as inner city) residents from receiving adequate health care and often outweigh strictly physical barriers. Rural residents have lower average incomes and higher poverty rates than do urban residents, with one

out of every six rural families living in poverty in 1989. While some rural areas have prospered, areas whose economies are based on farming and mining suffered real decreases in per capita income during the last half of the 1980s. Still other rural areas have been pockets of poverty for decades, e.g., the south.

While rural health care availability in 1993 was better in many ways than that of 20 years ago, the future prospect for rural health care in the absence of intervention appears grim. Rural America cannot support its present complement of hospitals, and those hospitals are going broke - this is especially true for the smallest of the rural hospitals. In 1992, the Prospective Payment Assessment Commission (ProPAC) reported that nearly 28 percent of all rural hospitals had negative total operating margins while 39 percent of rural hospitals of less than 50 beds had negative total margins. In Michigan, because of specific initiatives aimed at small, rural hospitals, the experience was slightly better, with 32 percent of those hospitals having negative total margins in 1992 (compared with 25 percent of all Michigan hospitals).

As regards the administration's proposal, we strongly support the provisions which provide incentives for alternatives to fee-for-service plans to be introduced in rural areas. This should help insure that health care can be accessed at lower costs. We support the idea that care can be delivered through organized Community Care Networks in rural areas, with payment on a capitated basis,

but not under the same rules and presumptions as in urban settings. Capitation rates to rural settings probably need to be higher than to urban networks, because of the need to recruit health professionals to rural settings, the need to purchase some services from outside the area, and the importance of reinsurance provisions to address the risk of smaller population bases.

Another necessary provision gives the alliance the authority to require contracting health plans to create health plan options in rural areas. There are numerous provisions which provide direct support or incentives to increase the number and availability of appropriate providers in rural areas, i.e., increased emphasis on primary care training and residency programs; increases in the number of non-physician providers; increased training authority for mental health and substance abuse; pre-emption of state laws that limit the scope of practice of non-physician health professional; grants to improve infrastructure and incentives to providers to locate in under-served areas; administrative simplicity; etc.

An example of an attempt to meet the need for additional primary care providers can be seen in an effort by Northern Michigan University to develop an advanced Family Nurse Practitioner training program. The purpose of the project is to prepare professional nurses as advanced practice nurses in family health, who will provide high quality health care services in primary,

secondary, and tertiary settings in rural, medically under-served communities, with the capability of practicing across clinical settings.

Graduates will have the knowledge and skills to manage the care of individuals and families across the life span and to plan programs of care for specific populations. This option of study synthesizes the knowledge and skills of the clinical nurse specialist with the knowledge and skills of the family nurse practitioner, into the role of advanced practice nurse in family health.

Nurse practitioners are usually prepared at the Master's level, and thus have additional education and experience as compared to physician assistants, and can practice nursing independently within the nursing scope of practice as defined by the State Board of Nursing. Many patients seen in rural areas have nursing problems and not medical problems. It may even be possible in the not-too-distant future to link these Master's prepared Family Nurse Practitioners in rural settings and connect them to regional specialty centers via fiber optics for information and consultation.

It is through the support of programs such as this, currently being proposed to the Division of Nursing within the Public Health Service of the Department of Health and Human Services, that we can begin to meet the needs of the under-served.

Inner City Delivery Problems

In 1988, 17 million residents lived in medically under-served urban areas - primary inner cities. These areas are unattractive to many physicians and may not be able to support an economically viable medical practice in the current system. The shortages are particularly acute for office-based primary care physicians. One study, reported by the Pepper Commission, found that the availability of such physicians was declining in poverty areas, despite growth in the overall number of practicing physicians. This puts even greater burden on our hospitals in these under-served areas: In 1990, members of the National Association of Public Hospitals averaged 260,000 emergency room and outpatient visits, and 18,000 admissions - more than 10 times the volume of the average hospital.

Compounding the problem in the inner city is the fact that health status, in general, is very poor in the under-served communities. In some neighborhoods in Chicago, for instance the infant mortality rate is more than 20 deaths per 1,000 live births, compared to a national rate of 8 deaths per live births. In Detroit, the 1991 infant mortality rate was 19.4 deaths per 1,000 live births, 23.1 deaths in Pontiac, 31.5 deaths in Highland Park, 20 deaths in Benton Harbor, and 12.8 deaths in my own city of Muskegon. In each location, the rate is much higher among minority populations than for whites.

Another problem for inner city health care reform based on managed competition is the fact that capitated plans will have to educate consumers about using the managed care system. As those familiar with inner city patient selection patterns know, most low income and Medicaid patients have been socialized to use the emergency room for their care.

Even if their health care is paid for, persons in poverty may face significant logistical barriers to care. For those who cannot afford to maintain a car, take public transportation, or pay taxicab fare, travel to medical care is a serious problem. When public transportation is available and affordable, the effort required to get from home to the source of care may be extraordinary. Providers' limited office hours can pose another obstacle for the working poor who cannot take time away from their jobs.

Minorities are more likely to be poor and thus to face the access barriers associated with poverty. They also face additional barriers arising from residence in the inner city, discrimination, and a variety of socioeconomic and cultural factors that make some individuals less disposed to seek necessary services even when those services are available.

The theory of universal coverage is that once everyone is insured, the poor will have the same access to health care as middle

Americans. Such is the premise of the administration's Health Security Act of 1993 (HR 3600). However, MHA is concerned that the plan will not proceed as smoothly as the White House hopes. Universal coverage does not equate to universal access. We see inner city hospitals continually struggling to serve the needs of their communities - falling further and further into economic distress - and becoming more and more unattractive to health plans which avoid under-served areas because of their residents' unique needs and inherently higher costs.

The Role of Essential Providers in Under-served Areas

Mr. Chairman, we applaud your longstanding support for public and private health professionals and institutions which have traditionally served a disproportionately larger share of our society's less fortunate. As you know better than most, these essential community providers, both professionals and institutions, are playing a critical role in our nation's patch-work health care delivery system. This is particularly true of many hospitals which pay the salary of their house staff who treat the uninsured and absorb the cost of the institutional services. Yet, the unreimbursed cost of providing their services in our nation's inner city and rural areas has, in many cases, substantially weakened their ability to compete for the covered patient with better located facilities. We expect that these same facilities will form the safety net for individuals, who, for whatever reason, fall

through the cracks in a reformed health care system.

We strongly endorse the underlying policy of the Health Security Act's essential community provider provisions. This policy acknowledges the willingness and ability of these providers to ensure access to the benefits of the comprehensive benefit package. However, we are concerned about the provision which limits the certification of additional essential community providers where the health plan operating in the area served by the applicant is able to assure adequate access only if the applicant is certified.

MHA believes that Congress has a duty to ensure that hospitals serving our inner cities' and rural areas' poor and less fortunate have a fair opportunity to participate in health care reform. Congress created the Medicare and Medicaid disproportionate share provider programs in the mid-'80s to ensure that these critical facilities were able to continue their essential community service. In their dedication to serving the uninsured and under-served populations, these institutions severely compromised their ability to compete for the insured population. Congress cannot abandon these institutions at a time when its support is most needed. Congress should ensure that these vital institutions are rewarded for their commitment to community service by ensuring that they are given reasonable time and financial protection necessary to best transition to the new delivery and financing system. We are not, however, advocating a guaranteed protection for these institutions, but rather a program that would give them the best opportunity to

make the necessary changes. If, however, after a reasonable transition period, the respective former-disproportionate share hospital is unable to adapt then the system should be allowed to continue its evolution without further interference.

Thus, we propose that for the first five years of the reformed delivery system current high disproportionate share hospitals should be grandfathered as an essential community provider without a requirement for certification. Further, we propose that all other disproportionate share hospitals be grandfathered for the first three years.

As most of today's disproportionate share hospitals are located in urban areas, special attention should be focused on rural essential community providers. The National Health Board and/or the Department of Health and Human Services should be required to pay particular attention to the issue of access in rural areas. In order to allow for a reasonable access transition, upon enactment of health care reform all rural facilities in designated health manpower shortage areas or which serve a medically under-served population should be deemed to be essential community providers as is accorded other classes of deemed facilities in the Health Security Act for a five year period.

Such grandfathered hospitals should not only receive the participation options of the Health Security Act but they should

also receive a supplemental per case payment amount, funded from a small premium assessment, which would allow these facilities to improve their attractiveness to health plans. Finally, such facilities should be exempted from any Medicare capital cuts.

Uncompensated Care and Health Care Reform

It is important to note that the Health Security Act's payment options for essential community providers only relates to services provided to a plan's member. The two payment options do nothing to address the economic consequences of years and years of providing uncompensated care. Further, the payment options do not provide any relief for the cost of uncompensated care under health care reform.

The Health Security Act recognizes that even comprehensive health care reform will still leave a residue of uncompensated care. However, this residue is not insubstantial. While no one has verifiable numbers it seem reasonable to assume the cost of uncompensated care in the context of the president's proposal will run significantly more than the \$800 million which would be authorized to pay for uncompensated care under the Health Security Act. It's not clear whether this \$800 million is part of or in addition to the \$1 billion the administration reportedly plans to spend per year to concentrate on regional health priorities, including reimbursement for the costs of undocumented residents,

AIDS and tuberculosis and for controlling violence in inner cities.

In particular, the amount noted in the Health Security Act for the cost of treating undocumented immigrants, e.g., 25 percent of the \$800 million, would not cover the costs of such services in the most heavily impacted states including California, Texas, Florida, New York, New Mexico, Illinois and Michigan. In fact, the State of California reported that providing emergency medical services, including labor and delivery services, to undocumented residents will cost the state approximately \$398.7 million for FY 1993-1994. In addition, California estimates it will spend \$82 million for prenatal services.

MHA believes that providers should not be arbitrarily penalized for the cost of uncompensated care under health care reform - yet that is what is being proposed with such a small uncompensated care fund. As regard uncompensated care burdens, we feel it is essential for Congress to ensure that all providers have the same opportunity to participate in a reformed health care delivery and financing system. Providers saddled with uncompensated care costs arising from undocumented immigrants and those unable or unwilling to follow the rules of the new health care system will always be at a competitive disadvantage to those without such burdens. Further, those providers may have their very existence threatened if the burden of unreimbursed care is great enough. Make no mistake, the rationale for many employers in supporting reform is to end any

cost shift for such patients; yet, the funds for these patients' care must come from somewhere. And while many provider networks are well under development, the early years of health care reform will be critical years as health plans line up participating providers. Health plans will be reluctant to contract with providers who bring uncompensated care to the plan's rate structure. Thus, Congress should essentially hold these providers harmless for the cost of uncompensated care.

The Adequacy of Provisions Supporting Providers in Organizing Integrated Delivery Systems.

The Health Security Act provides little assistance to the formation of integrated health plans by providers. This is because the health care reform proposal fails to constructively address the key problem areas of laws governing fraud and abuse, physician referrals, competitiveness and tax-exempt status.

Under current law, one provider agreement may comply with antitrust law, but not tax law. For instance, a hospital and its physicians could integrate in order to share financial risk and hence decrease the chance for an antitrust challenge. But if the hospital is tax-exempt and the physician group is not, the hospitals's tax-exempt status could be endangered.

Another problem is enforcement during the stages of integration.

Networks are rarely born fully integrated, and passage through some stages may cause tax, antitrust and fraud and abuse problems. We urge the Congress to support a policy which would direct the development of federal fraud and abuse, self-referral, antitrust, guidelines which would create regulatory flexibility for the evolution of a provider sponsored fully integrated delivery system.

A key area of concern for integrated delivery systems is antitrust. As providers merge and affiliate to form new entities that will provide a full continuum of care to payers, they must be attentive not to engage in anti-competitive activity. While recent guidelines from the Federal Trade Commission and the Department of Justice reflect a willingness on behalf of the administration to help providers with joint activities, we believe that they did not go far enough. In concept, the antitrust laws as regards integrated delivery system should apply to competition among networks not in their formation, i.e., the "intra-network" relationship should be looked at differently and allowed to develop.

The most problematic laws are the ones covering referrals - those contained in the anti-kickback and self-referral laws, which prevent physicians from referring to entities in which they have an ownership interest. The fraud and abuse laws, which would be extended to all payers under the administration's plan, will become less and less relevant as networks move to 100 percent capitation

payment. In the meantime, however, there is an urgent need for greater flexibility in the application of fraud and abuse laws. While the above noted new safe harbor rules which were proposed in September 1993 were described by the Secretary of Health and Human Services as "...not intended to unduly restrict individuals and entities from freely engaging in business practices and arrangements that encourage legitimate competition, innovation, and economy," that is exactly what they do. They are overly restrictive and too narrowly drawn and could hamper the delivery of health care services. Essentially they provide no assurances for the medical and health care industries. While we applaud the proposal to remove the "60/40" revenue rule for rural hospitals (no more than 40 percent of the gross revenue from an entity may come from referrals or business otherwise generated by investors) as well as the "60/40" investment rule, the same exceptions should be made for urban hospitals.

There is no recognition in the new rules of the inner city realities where, even in the largest metropolitan areas, some care just is not available.

Hospitals are placed in a very difficult position by limits on physician recruiting because they must hire physicians that allow them to meet Medicare conditions of participation, but cannot violate anti-kickback law is doing so.

The self-referral laws, which would be applicable to health plans under the Health Security Act, are a cause for varying concern. With some exceptions, these laws provide that physicians cannot refer Medicare or Medicaid patients to any entity with which they have a financial relationship for specific services. Included are inpatient and outpatient care. The problem is that the definition of "financial relationships" covered in the self-referral laws is very broad, and can mean receiving any remuneration. For example, a hospital and physician group co-own an imaging center, but none of the physicians refer to it. The hospital has contributed more to the venture than have the doctors, but they split the profits equally. Do the anti-referral laws prevent the physician group from admitting to the hospital? Hospitals need to know if financial arrangements in an integrated delivery system between hospital and physicians could be considered financial relationships under the self-referral laws, and, if so, the rules need to be changed.

Another area of concern for provider sponsored integrated health delivery system, particularly for tax-exempt facilities, is protecting the tax-exempt status for integrated delivery systems. However, tax-exempt sponsors are unsure of the Internal Revenue Service. For instance, a recent important IRS determination limited the number of physicians on a system's governing board to 20 percent. The IRS reasoned that a board composed of community members was the type of control it was looking for in integrated

delivery systems. Yet, it is important that physicians have a significant roll in the board control of the system - 20 percent seems an arbitrary number given physicians' pivotal nature in the system. Extension of this ruling to other systems could dramatically limit their involvement and thus, make them unwilling to participate in the respective venture.

We need clear explanations of how Federal agencies will enforce laws for integrated delivery system activity. And we need exceptions for some - particularly in regard to the evolution of capitated systems.

The linkage between delivery problems in rural and inner city America and provisions supporting provider sponsored integrated delivery systems is the commitment of hospitals to serve their communities - regardless of the location. Local control and commitment provides an invaluable assurance that the promised benefits of health care reform will, in fact, be available to these unique populations. Local providers working with and through integrated health care delivery systems can make good on the promises. However, they must have regulatory flexibility as regards laws and regulations which create barriers to economic collaboration among providers.

This support begins with the recognition from Congress that integrated delivery systems are desirable, even necessary, for national health reform to work.

Thank you again for your invitation. I would be please to answer any questions.

Mr. WAXMAN. Mr. Morrissey.

STATEMENT OF RICHARD MORRISSEY

Mr. MORRISSEY. Thank you, Mr. Chairman. I am Dick Morrissey, I am the Director of the unit in Kansas State government that has primary responsibility for primary care and rural health policy and development. The Office of Local and Rural Health Systems really started in 1989.

We have been focused on network development in rural areas from the beginning. We have done this through a partnership with several organizations, including our State hospital association, the Board of Emergency Medical Services and a local Kansas health foundation.

As a result of that effort, we were selected as one of the seven pilot States in the essential access community hospital program and we started out with 10 networks involving 43 hospitals. We soon learned that hospital-based networks were too narrow and couldn't solve the key issues of access to primary and preventive services in rural communities by themselves, and we then began development, testing of a system that integrates other primary care services along with acute care services in a full continuum. We call that Community Health Organization, and there is a depiction of that attached.

We have one other project that I think is of interest to you and that focuses on the issue of telemedicine. Again in partnership with the Kansas Hospital Association, we have conducted an 18-month study of telemedicine applications and the potential for those applications in the State.

That report will be published as a four-volume set later this month. It really begins with a focus on technology and what is available, the state of the art, discussion of policy issues, and really the focus is on a community planning guide.

What is different perhaps about our approach from some of the other work in telemedicine is we have focused on it from the standpoint of what the community needs and the kind of information that would assist communities and providers in assessing their needs and trying to come up with the best use of the technology.

Our experience in all of this process really brings me today to advocate for three key objectives really to health care reform. One is to encourage community based integrated health delivery systems. Second is to appropriately protect some of the fragile systems and resources in underserved areas, and three, to provide resources and authority for States to have an active role in supporting the development of rural health networks.

A rural health delivery system needs to have an ability to coordinate services, to minimize duplication, contain costs, and assure access to a comprehensive range of services. The Health Security Act recognizes the need to integrate services through the provisions to create community practice networks.

Unfortunately, the act does not integrate prehospital emergency services nor public health services into the proposed networks, and also omits from the network sole community providers, essential access community hospitals and primary care hospitals, all important rural resources.

The function of a community-based rural health community system is one where the community, not just health care providers is involved in the planning, management and even ownership of the system. Our experience and experience in research from around the country support the notion that community involvement is critical to solving the problems that stand in the way of successful rural health systems.

Specific enabling language would enhance the focus and involvement of communities in solving rural health delivery problems.

There is a need to protect the fragile systems and resources in rural underserved areas and you have heard a good deal about that already. The act addresses this concern in a number of ways, in differential payments and essential community providers. Those are important.

A number of other providers need to be included, and this is a point where I come back to Congressman Slattery's earlier statement about the need for some flexibility for States to be able to tailor these protections to the situations that apply given their geography, population, and a range of other factors.

One of our problems with the system right now is the use of health professional shortage areas, medically underserved areas as currently structured in the law and regulations. If these are used to define eligibility for participation in practice networks and for other protections and benefits of the act, we are going to continue to have areas of our State and in fact areas of large parts of the western half of the United States excluded from participation based upon the different nature of the rural areas. Frontier areas as far as population, long distances, and an aging population with chronic disease needs are not well served by these criteria.

This issue is not new but it will take on great new significance as a barrier to rural health network development if not addressed in conjunction with health care reform.

The act makes development grant funding available to community practice networks but provides no other resources to assist in their development. I think one of the things we have learned is that communities and the resources available to support communities and developing networks are not adequate.

There is a key role that can be played by State governments here, and we think the EACH program has given us the opportunity to test that role and demonstrate that in fact we can provide the coordination and technical support in the development of those projects.

Thank you very much, Mr. Chairman.

Mr. WAXMAN. Thank you very much, Mr. Morrissey.

[The prepared statement of Mr. Morrissey follows:]

TESTIMONY

PRESENTED TO
HOUSE COMMITTEE ON ENERGY AND COMMERCE
SUBCOMMITTEE ON HEALTH AND ENVIRONMENT

JANUARY 25, 1994

BY

RICHARD MORRISSEY, DIRECTOR
OFFICE OF LOCAL AND RURAL HEALTH SYSTEMS
KANSAS DEPARTMENT OF HEALTH AND ENVIRONMENT

Mr. Chairman, Distinguished Members of the Committee, my name is Richard Morrissey and I am the Director of the unit in Kansas state government responsible for rural health and primary care policy and development. I have been involved in health care in Kansas as a regulator, administrator, and policy planner for nearly twenty years.

The Office of Local and Rural Health Systems was established in 1989 to focus on rural health and primary care policy issues. In 1990, we formed a public/private partnership to pursue the development of rural health networks through the Essential Access Community Hospital (EACH) Program; called the Rural Health Options Project, the partners include the Kansas Department of Health and Environment, the Kansas Hospital Association, the Board of Emergency Medical Services, and the Kansas Health Foundation. We were selected as one of the 7 pilot states in the EACH Program and started with 10 networks involving 43 hospitals. We learned early on that by limiting participation to hospitals only, the networks were too narrow to effectively address the key issue of access to primary and preventive services in rural communities. We therefore began development and testing of a Community Health Organization model for more comprehensive integration of health services. (see Figure 1) The Partnership has also participated with Kansas Health Foundation

support in the Integrated Community Health Development Project wherein ten rural communities have assessed their health needs and service delivery systems and developed plans to build integrated systems of care to assure local access to core services.

The Kansas Department of Health and Environment and the Kansas Hospital Association have also completed a study of the potential for telecommunications to address significant problems in underserved areas. Telemedicine: Assessing the Kansas Environment will be published as a four volume report at the end of this month. The report is aimed at rural community and health provider users and provides information on the technological "state of the art," the communications infrastructure, and telecommunications applications that are available. The report includes a discussion of key telemedicine policy issues and a detailed planning guide for communities to use in selecting and implementing the most helpful telemedicine technology for their situation.

Our experience in this process brings me here today to advocate for health reform provisions which promote three key objectives related to rural health delivery systems: (1) to encourage community based, integrated health delivery systems; (2) to appropriately protect the fragile systems and resources in rural underserved areas; and (3) to provide the resources and authority for states to have an active role in supporting the development of rural health networks and systems.

Community Based, Integrated Health Delivery Systems

The rural health delivery system is not limited to a physician and hospital. A rural health delivery system needs to have the ability to coordinate services and resources

to minimize duplication, contain costs and assure access to a comprehensive range of services. The system needs to be inclusive of all the services displayed in Figure 1 and assure local access to pre-hospital emergency services, primary care services, public health services, and home based long term care services. The Health Security Act recognizes the need to integrate services through the provisions to create "Community Practice Networks." Unfortunately, the Act does not integrate pre-hospital emergency services nor public health services into the proposed networks. Not only are these critical in the continuum of care for access purposes, but the public health services are the primary resource in rural areas to assure the objective of developing a focus on disease prevention and health promotion in a reformed system. The Act also omits from the networks sole community providers, essential access community hospitals and primary care hospitals, all important rural resources.

A community based rural health delivery system is one where the community, not just health care providers, is involved in the planning, management and even ownership of the system. Experience and research from around the country support the notion that community involvement is critical to solving the problems that stand in the way of successful rural health systems. The Act is silent on the issue, but specific enabling language would enhance development of community based systems.

Fragile Systems and Resources in Rural Underserved Areas

The promise of health care reform comes with some potential threats for rural areas. Will the financing method impede or prevent development of community health systems? Will incentives be created that continue or increase the drain of human resources? The Act addresses the latter concern through an increase in the

differential payment for Medicare patients from ten percent to twenty percent and through the concept of "essential community providers." This proposal is important and protects the investment made in several types of providers. However, sole community providers and rural primary care hospitals should be included.

The use of health professional shortage areas and medically underserved areas, as currently structured in the law and regulations, to define eligibility for participation in community practice networks and for the other protections and benefits in the Act will be problematic for half the country. The western half of the United States has very few designated shortage areas because the criteria used are heavily weighted to poverty status and health status as measured by infant mortality. Frontier areas with sparse population, long distances, and an aging population with chronic disease needs are not well served by these criteria. Moreover, the "rational service area" criteria used for health professional shortage areas results in unrealistically small service areas for Frontier regions. This issue is not new, but it will take on great new significance as a barrier to rural health network development if not addressed in conjunction with health care reform.

Anti-trust concerns are still real barriers to network development. Whether the threat of anti-trust actions is real or perceived is immaterial. The Act does not speak to anti-trust issues with respect to community practice networks. If the source of the necessary protection is to be the state action doctrine, one major problem will be the inability to extend protection to networks that cross state lines. These situations are common in rural state line border areas. A more direct approach to resolving the issue in federal law would enhance network development.

State Role in Network Development

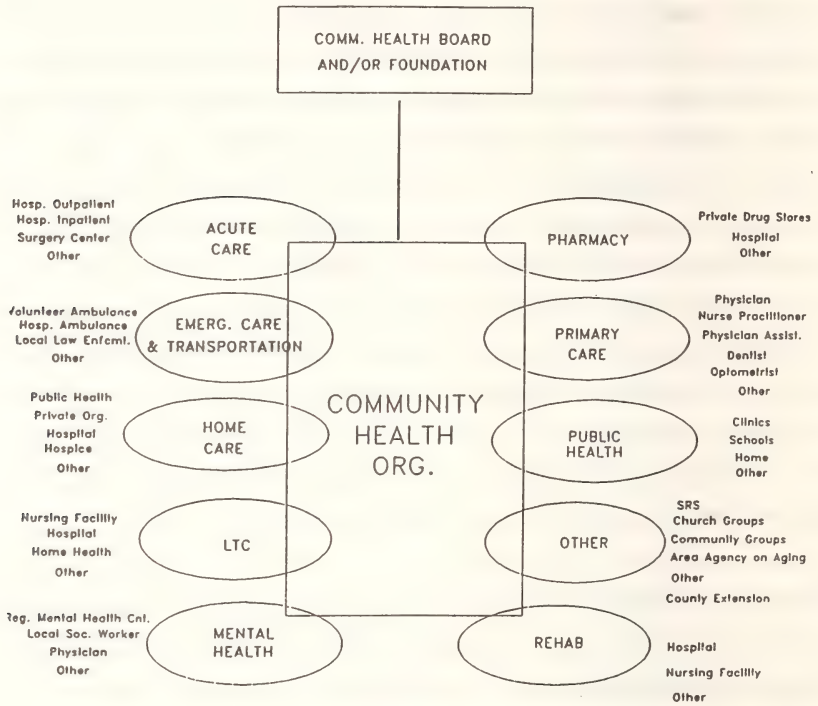
The Act makes development grant funding available to community practice networks but provides no other resources to assist in their development. The EACH program provides a model of state involvement that has been tested and shown to work in seven diverse states- California, South Dakota, Colorado, Kansas, West Virginia, New York and North Carolina. The states provide policy development, technical assistance and coordination of development and technical assistance activities across communities and networks. Not only are the states in a position to coordinate and provide assistance, they are also advocates for the community programs. The diversity of the approaches to these functions in the seven states demonstrates the flexibility that can accompany a significant state role. The EACH program states have worked in a cooperative development process with the Health Care Financing Administration and the Robert Wood Johnson foundation. The federal/ state/ private relationship has been both functional and productive. Though not all states have the same experience and capacity, we have the ability to transfer the necessary technology to those that do not. All states have now established offices focusing on rural health policy and the resources are in place in technical assistance programs and rural health research centers to implement such an effort.

There are insufficient resources with the required expertise to begin network development efforts in communities across the country. From a practical standpoint, some mechanism will be required to coordinate the process among communities. State governments will likely be involved in other significant functions of the reform program and are the most logical resources to develop the capacity to promote and support rural health networks.

FIGURE 1

COMMUNITY HEALTH ORGANIZATION

An Integrated Health Services System



FUNDING/PAYMENT SOURCES

MEDICARE	LOCAL	TAXES	PAYERS/	INDIVIDUAL
MEDICAID	GOVERNMENT		EMPLOYERS	PAYERS

Mr. WAXMAN. Mr. Splinter.

STATEMENT OF GARTH SPLINTER

Mr. SPLINTER. Thank you very much, Mr. Chairman. It is my great pleasure to be here today. I would like to add for the record that I am a family physician and I have served for the last three years as health adviser to Governor David Walters, Oklahoma.

I was asked today to speak on telemedicine and what we are doing in Oklahoma and our view towards some of the useful changes that we might have in this area. To put it into perspective, with health care reform going on in the State and our awareness of the national reform level, we have two major things that we look at.

One is that we want a system that is as distributed as possible with care staying at the local level as long as is appropriate, and we certainly believe that the future of medicine or health care delivery will be with vertically integrated delivery systems.

We believe that telemedicine addresses both of these areas and allows for direct care of the patient through consultation, review of medical information, allowing that goal of the distributed network to be achieved.

We think that with the accountable health plan, vertical integrated delivery system approach, that telemedicine will bind together these geographically distributed systems and allow them to function more effectively, and I would include, given the earlier testimony today, I think that may be one of the major tragedies for health science centers, to bring this same technology, to bring together dispersed faculty and facilities at the academic health centers.

Telemedicine can also be used for the support of mid-level practitioners and in the same way that it can be used for primary care physicians. We think it can also be used for targeted interventions, such as corrections. We have a great problem in Oklahoma with having adequate health care in the correctional facilities.

With mid-level practitioners backed up by physician care over telemedicine networks, we think we can address this problem, and there is a variety of miscellaneous areas that can be addressed: Continuing medical education, electronic mail bulletin boards, recruitment in rural areas.

We found already through our experience that they feel more comfortable in rural areas if they have the backup of this technology, and practice-based research as we move forward, especially with electronic medical records.

In Oklahoma, we have four major areas currently under way that I think are significant. The Oklahoma telemedicine network is a \$5.1 million project already funded with a combination of private and government funds. It involves 46 hospitals in a two-year project to by equipment and fund line charges for two years.

We also have up to 20 regional hospitals that have expressed an interest with purely private dollars into coming into the network. The RFP for the system design is being prepared by the University of Oklahoma Health Science Center and will be let soon.

It is important to note that the design is an open system approach. We believe that it is extremely important that any point on

the network can access any other point. What we would like to do is have physicians or medical personnel, hospitals, be able to access any specialist in the State, and in essence have competition over an electronic network.

We have a smaller project, \$500,000 project under way called the Oklahoma Medical Information Network. It is six sites, mainly directed towards testing products and improving concepts. We are currently digitalizing and transmitting x rays and being reimbursed by HCFA for that. They go from Hugo, Oklahoma to the VA hospital in Oklahoma City for reading. That again is being done by the University of Oklahoma Health Science Center.

One of the products being developed there by the ophthalmology director is doing retinal scans from rural areas and having them read by ophthalmologists in Oklahoma City.

We have a project about to be funded at OSU College of Osteopathic Medicine for \$400,000. They will be testing digitalized video networks, which is really a cutting edge approach to a necessary component, we think, of having live interaction for consultation.

There is quite a bit of discussion about whether we should use digital versus analog. Many of the networks now are analog or traditional TV approaches, but digital signals give the opportunity to have any point access any other point and ultimately will be a cheaper approach.

We have several private projects. Most of those are analog video conferencing, and so we have quite a bit of discussion going on with them hoping to get them moving in the same way as the other projects.

As far as the Clinton plan, we are very supportive of the Clinton plan in regards to the telemedicine approach. The vertical integration aspects of the support of the accountable health plans and ultimately the vertical integration of the delivery system will create a need for this type of technology.

The primary care provider provisions that have been discussed today will of course give us the providers that we need out in the rural areas, and there is direct support of the rural telecommunication infrastructure which we will find useful.

I will make some brief recommendations that we would find useful in this whole approach if the Federal Government was involved in developing standards, especially for networks for medical records. Moving HCFA towards payment for these services would be a great incentive. The proposed information superhighway will be helpful.

We have some potential problems with tariffs and area codes, and public health departments do need direct support to be able to link into these networks.

Again, Mr. Chairman, thank you very much for allowing these comments.

Mr. WAXMAN. Thank you very much for your testimony.

[The prepared statement of Mr. Splinter follows:]

WRITTEN TESTIMONY OF GARTH L. SPLINTER MD, MBA
BEFORE THE SUBCOMMITTEE ON
HEALTH AND ENVIRONMENT OF THE COMMITTEE ON
ENERGY AND COMMERCE
REPRESENTATIVE WAXMAN, CHAIR
WASHINGTON, D.C.
JANUARY 25, 1994

Mr. Chairman, I appreciate this opportunity to appear before this subcommittee to discuss the status of Telemedicine in Oklahoma and the Oklahoma view of the Clinton health plan in regards to telemedicine. Oklahoma State Government, the major state universities, and private health care entities in Oklahoma are all active in the development of this technology.

As part of our ongoing effort with health care system reform, we have been developing a vision of what the health care delivery system in Oklahoma should be in the future. Two clearly emerging themes are technical support of rural physicians and hospitals to retain patients in these locations as long as is appropriate and movement toward the development of vertically integrated delivery systems in the state (usually referred to as accountable health plans).

Telemedicine is extremely important in the development both of these themes in that it directly supports the transmission of information for support of patients in the rural setting and also serves as the "glue" to tie together integrated networks. Furthermore, the same approach can be used to link together urban distributed systems of care, including health science centers, and can be used for smaller problem areas such as support of delivery of medical care by mid-level practitioners in correctional facilities. As alluded to above, a main use of the telemedicine network will be for practice support, however, it can also be used for continuing medical education, enhancing physician recruitment, and practice based research.

In Oklahoma we currently have several major projects under way to both support the development of, and the use of, a telemedicine network. The Oklahoma Telemedicine Network (OTN) is funded by 3.8 million dollars in community development block grant money from the Department of Housing and Urban Development. This was provided under the public service provision of this grant. These funds along with 1.3 million of private dollars will fund the equipment, installation and training charges for 46 hospitals as well as online costs (T1 lines) for 2 years. In addition, up to 20 regional hospitals have indicated an interest in linking to this project and will be funded totally with private dollars. These grant moneys have come through our Oklahoma Department of Commerce with the University of Oklahoma Health Sciences Center serving as the administrator of the contract. Currently, an RFP is being prepared to both set network specifications and acquire a network administrator for the project.

The OTN network is being designed as an open system. By this, we mean that from any point on the system any other point may be accessed. The implications for this are that rural hospitals will be able to shop for consultative or support services over the entire network. This will result in competition amongst tertiary centers and specialty providers which will help ensure that prices are kept to a minimum as well as maintaining customer service and satisfaction.

One of the facilities on the Oklahoma Telemedicine Network will be the Justice Center in Tulsa. The Justice Center in Tulsa is a national resource dedicated to the detection of and prevention of child abuse. Once on the network, rural hospitals can send diagnostic quality digital images and video clips of children to the experts in the center. The Justice Center is also staffed by the Department of Human Services, the police, and other state agencies. These resources would also be available to the hospitals on the network.

Another project, the Oklahoma Medical Information Network (OMIN), has been underway for several months, and was funded by a \$500,000 grant from special funds through the Governor's Office provided to the University of Oklahoma Health Sciences Center. This money funds 6 sites (4 of whom are in the OTN described above) and is designed primarily to test capability, line configurations, and software products in a setting that includes both rural, regional and tertiary centers. Most of the OMNI funds have been used for equipment purchases with the hospital paying line charges. Currently, one facility is transmitting digitalized scanned x-rays. Payments for radiological services over the network are made by the Health Care Financing Administration.

A second project is expected to be supported by special funds from the Governor's Office. This grant will provide \$300,000 and will be given to Oklahoma State University (OSU), College of Medicine, to develop a digital video overlay for the basic OTN project. Our current assessment indicates that real time digital video is not yet cost effective but at the current rate of technological improvement may be feasible in approximately 2 years. The OSU project will be a pilot demonstration testing currently available equipment, determining necessary resolution and picture size for adequate doctor/patient interaction, determining required bandwidth for transmission, and developing standards to allow payment for consultative services over a network. It is our belief that even though some work is currently proceeding with analog video (television based) networks, the future for network development will be digital. This is more compatible with the open network design and should be less expensive in the long run.

Also, we have several private projects underway, with most of these attempting to coordinate with the Oklahoma Telemedicine Network Project. Prominent among these are the Voluntary Hospital Association (VHA) group of 30 hospitals (16 of whom are in the OTN project) that are developing a real time live video network. There is much discussion about the future of analog signals versus

digital, but at this point the VHA hospitals believe that analog TV is appropriate based on their intended applications to business meetings, education, and teleconsultation.

The Clinton Plan in general is supportive of all of our development efforts. By encouraging the development of vertically integrated delivery systems or accountable health plans, it creates a need for the type of information flows that we foresee an electronic network providing. Also, there are specific recommendations for grants for telecommunications capacity in the rural areas and for the development of information and referral infrastructure in the rural areas. We are very supportive of these approaches.

We do think that there are some specific requirements that the federal government can address either through clarification of the Clinton proposal or other legislation. These include developing standards for digital networks so that all state systems will be compatible allowing some services to be bought at a national level in the future. In conjunction with this, standards for electronic medical records and supportive research into products will be very helpful. Examples of products are software currently being developed by the Ophthalmology Department at the University of Oklahoma which will allow scanning and transmission of retinal images so that ophthalmologists in Oklahoma City can monitor diabetic or other patients in rural sites, and development of multimedia patient cases by the Geriatrics Department at the University of Oklahoma for continuing medical education purposes.

Also of great importance to encouraging development in this area is the adoption of standards which allow payments for services, especially telemedicine consultations. We recently met with the Health Care Financing Administration on this subject and know that they are working on a reimbursement schedule. However, any encouragement as to a quick resolution would be helpful to those of us at the state level. In addition, the development of the proposed information super highway will make the whole process easier, since a statewide open telemedicine network is a subset of this project. The issues of separate area codes within the state and related tariffs may be a significant barrier to implementation and deserve study. Lastly, I would state that public health departments should be tied into this system with direct grant support to the states for equipment and initial start up charges.

Mr. Chairman thank you very much for the opportunity to testify before you today. I hope that these comments will be helpful and I look forward to progress in resolving our general problems with health care delivery and financing as well as specifically in telemedicine. If I can be of any additional assistance to you or other members, please feel free to contact me.

Mr. WAXMAN. Ms. Miller.

STATEMENT OF CAROL MILLER

Ms. MILLER. Thank you. In my written testimony, you will find a number of specific amendments to the Health Security Act that I am proposing.

In November, I testified to the Senate about some of the financing problems, and I want to share a couple of my opinions about the financing. Congressman Slattery raised a concern about basing a lot of the financing on Medicare, so I am not going to go into that, although for rural providers, it is a real concern.

I am going to focus on the institutionalization of historical cost as a basis for setting budgets. There is real concern in rural America that we are traditionally lower cost States and if you look at the financing mechanism, it sets up what you spend now is kind of what you are going to get to spend in the future, and there is a commission that is set up that will report back to the Congress in seven years, but we feel that that amount of time is excessive and that it will keep us under this historical spending for many more years than is necessary.

In fact, I served on the task force of Mrs. Clinton, and we repeatedly tried to argue the rural advocates that budgets not be based on historical spending, so it was discouraging that that methodology was selected.

One alternate methodology that we had considered in the task force and that I would still propose is some kind of transitional formula which would blend and average national per capita with some historical method. What will happen is the high cost, high-waste States will continue to have higher costs and the rural States, for the most part, which have been low cost States, will not have adequate budgets to provide the universal coverage in the comprehensive benefit package.

Another problem on the financing is that the Federal subsidy has been capped, and originally, certainly working on the task force, we thought that that was going to be more like an entitlement. It is called the Capped Entitlement, and I am not sure if that is even a possibility to put those two words together, but coming from a high subsidy State like New Mexico which has high unemployment, lots of low wage workers, we are very concerned that the amounts that are proposed in the subsidy will not cover all of the people who need that, and that once again there will not be enough money available to States to actually make sure that the budget is adequate to cover everybody.

We feel that the National Rural Health Association, that rural representation on boards is a key issue and it has not been addressed. We would like to see a rural representative on the National Health Board. One out of every four Americans lives in a rural area and it might be useful for that, but it is especially important that we have rural representatives on the boards of directors of health alliances.

Those alliances will be making decisions about what plans will operate, what the boundaries of those plans are, and we are very concerned that if we do not have rural representation, both em-

ployer and employee on those boards, that the needs of rural providers will not be addressed, and also rural consumers.

Just quickly, I want to say that we feel the essential community provider designation must continue. Some people who initially will be considered essentially community providers may, in fact, successfully integrate into networks, but there will be other communities that will not be able to and new communities that are not essential community providers by the definitions now, may, in fact, become essential community providers.

I want to try and get across the plan that we are hearing in rural America, and that I hear a lot now, is that there is a lot of skepticism about the reform. For example, the National Health Service Corps right now is frozen. I work for an organization that had a match with a physician assistant and we were told that because of the freeze, that couldn't go through.

Being from New Mexico, I work with a lot of Indian health service programs. They are being faced right now with very serious cut-backs, so there is a concern about the transition, and also what is happening right now before we even pass reform.

Some of us can't wait for the National Health Service Corps to meet this optimal number we hear about from the administration when right today we have critical vacancies that we can't fill even when someone wants to come.

I think that that skepticism is going to be very hard for rural America to overcome, and I think that we are hoping that the committee will help us address it.

One thing I want to say, being from a frontier community, is that even our model communities are incredibly fragile systems. The loss of a single provider sometimes will unravel the entire health care system. I think that we need to be very cognizant of that, be very gentle in the way that we implement the reform.

Thank you.

Mr. WAXMAN. Thank you very much for your testimony.

[Testimony resumes on p. 570.]

[The prepared statement of Ms. Miller follows:]

**TESTIMONY OF
CAROL MILLER, TRUSTEE
NATIONAL RURAL HEALTH ASSOCIATION**

Mr. Chairman and Members of the Committee,

Thank you very much for providing me this opportunity to share with you my initial assessment of how the President's Health Security Act will impact rural America. I have lived in a frontier mountain village in northern New Mexico for the past eighteen years. This community of about 200 people lives in a fold of the Sangre de Cristo Mountains adjacent to the Pecos Wilderness Area. In good weather we are a one hour drive to the closest hospital. I bring my personal daily reality to my professional analysis of health reform.

I am here today representing the National Rural Health Association. I serve as a Trustee of the National Rural Health Association, elected by the Frontier Constituency Group as their representative to the Board of Trustees.

National Rural Health Association Adopts Eight "Necessary Components"

That are Essential to the Success of Health Reform in Rural America

The National Rural Health Association represents members from across the entire geographic continuum; people who work in hospitals, health centers, state offices of rural health; as clinicians, administrators, educators and researchers. In a September 1992 white paper, National Health Policy Reform: The Rural Perspective, NRHA sets forth its position and the eight Necessary Components by which we evaluate all health reform proposals. (Excerpts from this paper are attached.)

The eight Necessary Components are:

1. universal access
2. federal leadership
3. state and local self-determination
4. community development

Development of comprehensive local health care systems that promote the building of local economic and social infrastructure.

5. consumer choice
6. financing incentives
7. education and training

To assure a sufficient number and mix of providers to meet the needs of underserved areas.

8. quality and efficiency

When we applied these Necessary Components to the Health Security Act, we found that it did well on some like choice and badly on others like state and local self-determination and community development. We are looking to the Congress to guarantee that any reform passed will truly be a national reform and work everywhere in the nation. Later this week, the NRHA Rural Health Policy Board will devote an entire day to the consideration of Congressional health reform proposals and the continued development of NRHA positions on the bills.

Because time is limited today, I will summarize four key issues at this hearing with my written testimony providing more detail: 1.) understanding the rural continuum;

2.) the necessity of rural participation in reform at the community, state, and national levels; 3.) Essential Community Providers and the fragility of the rural health care system; and 4.) the serious problems with the proposed financing of the Health Security Act.

The Rural Continuum

When I ask people to think about the first image that comes to mind when they think about rural America I get a range of responses. Some think about the small towns of New England with a green commons and a church with a white steeple. Others think about the Midwest, green rolling hills covered by corn and dotted with red barns. Others will think of the west, open range, dry land made green in patches by irrigation, grazing cattle, mountains off in the distance. I spent a lot of time in Alaska this Fall working with their state leaders on state health reform legislation. I have added the Alaskan reality to my conception of rural - pushing beyond a frontier definition to an understanding of wilderness. All of these images - and even more that I haven't named - are part of what we commonly define as rural, each presents unique and very different challenges to the health care system and each will be impacted differently by health reform. Ours is a very large and diverse country and the challenge is in designing and supporting a health care system that provides all of us access to affordable, high quality health care.

The reason that I like to talk about the rural continuum is that it allows these regional and community differences to be placed upon the table and considered rather than a

generic, shotgun approach to rural with a capital "R" which ends up not meeting the needs of any rural community. The continuum is a progression from rural to frontier to wilderness - moving from the most populated to the least populated. When I talk about rural health reform, I am speaking about the whole continuum and only using the generic term to save time. Problems with the current system follow this same continuum with more providers and access in rural areas, less in frontier, and almost none in the wilderness. One size fits all health reform will not work in rural America.

I must caution you, that when you hear rural advocates speaking in favor of or in opposition to various aspects of the Clinton and other health reform proposals, it is very important to find out where they are from because the rural movement spans the spectrum of opinion. For example, many rural advocates come from states which have good access even in rural areas, well established provider networks, and rates of uninsured as low as 8%. This is very different from my experience in frontier New Mexico where we have documented rates of uninsurance as high as 76% in a Community Health Center service area, where only 6% are covered by Medicaid, and where recruiting a doctor can take five years even when designated a high priority vacancy by the National Health Service Corps.

Community Self-determination - Necessity of Rural Participation in Reform at the Community, State, and National Levels

Community self-determination is the essence of successful health reform, not only for rural communities, but for all communities. One out of every four Americans lives in a

rural area. The National Rural Health Association believes that rural leaders should be involved in the policy and regulatory process. For example the section of the Health Security Act that lists the Basis of Selection for appointment to the National Health Board (Title I, Subtitle F, Sec. 1502, (b)) should be amended to include experience and expertise in rural health care. All other national committees, commissions, and task forces should also be required to have rural representation.

Rural representation should also be required on state boards and commissions. It is especially important that rural communities be guaranteed representation on the Board of Directors of the Health Alliances since this body will be making the critical decisions about how service areas will be established, which health plans will be available and at what cost, as well as monitoring marketing, grievances, and quality of care. Membership on Health Alliance Boards of Directors (Title I, Subtitle D, Part 1, Sec. 1302 (b)(1)(A) and (B)) should be amended to require that both the employer and employee membership reflect the geographic areas served by the alliance.

We hear over and over about the rapidly increasing percentage of national GDP represented by the health care sector. Reform has serious implications for local economies. In rural communities, institutional health care providers are usually the largest employers in the community. Changes in the organization of the health care system have far reaching economic consequences for rural communities and will impact economic development, and ultimately the future of rural America.

Essential Community Providers and the Fragility of the Rural Health Care System

I know that this committee is holding other hearings specifically addressing the Essential Community Provider provisions in the Health Security Act, but I feel I must stress how important this designation is for underserved communities, urban and rural. The National Rural Health Association is very sensitive to the barriers to health care faced by inner city populations. We know that the guarantees we seek for rural communities, will also benefit urban underserved communities. We have joined with other "safety net" providers in an Access Coalition to work for true health reform that eliminates not only financial barriers to care, but also the non-financial barriers such as lack of transportation, disability, language, membership in a disadvantaged population (racial or ethnic, homeless, public housing), or residence in an inner city or rural area. An insurance card alone will not provide these groups with health security.

I want to state for the record - there will always need to be entities designated as Essential Community Providers. There will always need to be providers receiving special financial assistance from government; federal, state, and local. We will always need to assure that a health care safety net is available for people. The Essential Community Providers of today may not all be the ECP's of the future. Many of them may become successfully integrated into networks and not need special protections even within the first five years of reform. But many will not be successfully integrated.

Communities that currently do not have ECP's may be negatively impacted by reform and its providers may need to be designated ECP's and provided financial assistance. It is unrealistic to develop a reform plan that assumes that by five years everyone will have equal access to health care.

We already have a shortage of appropriate health care providers that is at a crisis level. Health professions educators tell us that it may be almost a generation before we have enough providers available. Many rural primary care physicians are close to retirement age. Rural communities fear that reform will cause a net loss of providers.

One difference between urban and rural underserved areas that I must stress today is the fragility of many rural and all frontier health care systems. The smaller the size of a local health care delivery system, the more fragile it is. I have worked for the past 12 years at La Clinica del Pueblo, a frontier health care system in Tierra Amarilla, New Mexico. We have medical and dental clinics, provide home health care, offer a Community Outreach Program providing mental health, social services, and crisis intervention programs, a school-based clinic at Escalante High School, pay for speciality referrals for indigent patients, and operate one of the only paramedic-led (ALS) frontier ambulance services in the United States. We are considered a model program. Last month the General Accounting Office had staff looking at our school-based clinic. The Teen Wellness Center provides primary and urgent care, health education, counseling and support groups. We provide family planning on site because for this particular population it is an essential component of comprehensive

primary care.

Yet, all of us involved in the administration and planning for La Clinica know how fragile our system is. Loss of one key staff in a frontier health care system can turn a model program into a struggling program, hanging on by a thread to keep services available to the community. We were one of the first National Health Service Corps sites in the United States. In 1992 we became a Community Health Center. We believe that we will always need to be designated an Essential Community Provider and that our community will always need help from the federal government.

As the National Rural Health Association Trustee representing frontier communities, I hear similar sad stories over and over again. The frontier suffers the "boom and bust syndrome" of the health economy with the whole system hinging on one or two key people. A hospital closes, a provider moves, retires or even just gets sick, and the whole health care system unravels in that community.

I must add one more point before leaving the topic of Essential Community Providers. I also serve as President of the New Mexico Public Health Association. We are very concerned about the decision to exclude undocumented workers from health reform. We favor amending the Health Security Act with language similar to that contained in S.491, The American Health Security Act which allows the National Health Board to make eligible for benefits other individuals in order: "(a) to preserve the public health of communities, (B) to compensate States for the additional health care financing

burdens created by such individuals, and (C) to prevent adverse financial and medical consequences of uncompensated care." S. 491 also allows any state to expand coverage to undocumented workers at the expense of the state.

Although working for this amendment is a primary activity of the New Mexico Public Health Association, coverage of undocumented workers is not a border issue, it is a national issue. For example there are large populations of Russians in Alaska and Los Angeles, Irish in Boston, Italians in New York, Eastern Europeans in Chicago, Chinese in New York, and on and on. Estimates of the population of undocumented workers range from 5 million to 10 million. I call these people undocumented workers because they come to the United States to work. Most of them are employed and contributing to the economy. Many of them will be paying for health care through the payroll premiums, but will not be able to access their pre-paid health care. Therefore, we will have to retain providers of care to undocumented workers as Essential Community Providers. The question is not whether we can afford to provide them with coverage, but rather can we afford not to provide coverage?

Reform Financing Mechanisms - Rural Friend or Foe

In November I presented testimony on the serious problems with the proposed financing of the Health Security Act to the Senate Committee on Labor and Human Resources. I want to share with this Committee those same concerns.

A. Financing reform through cuts in Medicare

Rural health care providers of Medicare Part A and Part B health services feel extremely threatened by the plans to finance much of health reform with cuts in the Medicare program. Because rural communities frequently have higher percentages of elderly residents, rural providers are more dependent on Medicare revenues than urban providers. Medicare recipients make up the majority of patients receiving in-patient care in rural hospitals and make up the majority of patients seen by rural health providers. Medicare already pays only 90 cents on the dollar. The plight of rural hospitals has been heard many times by this committee and other members of Congress. We must make sure that providers serving Medicare recipients are fairly compensated for the care. We can not afford a reformed system which continues cost shifting.

B. Institutionalization of historical cost factors in establishing budgets, premiums and subsidy levels for alliances and plans

I would like to ask this committee to carefully study **Section 6006 (Health Security Act) Recommendations to Eliminate Regional Variations in Alliance Targets Due to Variation in Practice Patterns; Congressional Consideration**. Every policy paper, tollgate, and meeting of the rural workgroups throughout the entire life of the Health Care Task Force unanimously rejected historical spending as a basis of establishing targets and budgets for the financing of health reform. Yet we lost this battle and Congress has been presented a bill which ignores our pleas for equitable payment.

- Using historical spending as a starting point rewards the providers who have been the most costly in the past.
- Differential payments based on historical spending already contributes to the shortage of health care providers in rural areas.
- Using historical spending is double jeopardy for rural providers who have been paid less despite the fact that their unit costs are higher because they are not able to achieve volume savings or economies of scale.

Although in most rural areas, historical spending has been lower than in urban areas, it may need to be higher in order to assure geographic access to rural Americans. Recruitment and retention incentives will be necessary to expand the numbers of providers working in rural areas. Reimbursement in many rural communities will need to be cost-based rather than charge-based to fairly cover the cost of a rural practice and/or facility.

Section 6006. establishes a commission to report to the Congress on eliminating regional variations in alliance targets due to variations in practice patterns, historical variation among State Medicaid plans, State maintenance of effort payments for non-cash assistance recipients and those that are attributable to historical differences. *These differences will not be eliminated until the year 2002* and must remain budget neutral. Rural providers are already at the edge of the financial cliff. They cannot wait seven years for a Commission and Congress to compensate them fairly.

In order to assure the survival of the rural health care system during the transition to national health reform, a fair rate must be established before the implementation begins. One interim step may be to look at a transition formula which blends historical spending with a national per capita average.

C. Capping of the federal subsidy.

I come from New Mexico which is going to be a "high subsidy state," needing the Federal subsidy for low income families, the unemployed, low wage workers, seasonal workers, self-employed below 250% of poverty and the all of the other categories eligible for the Federal subsidy.

Title IX, Subtitle B, section 9102 Capped Federal Alliance Payments, describes a "Capped Entitlement" which sounds like an oxymoron to me. I am afraid that when health reform begins to cost more than anticipated and since the employer and individual shares are capped, that the only place to find additional funds will be through the Federal share - a ratcheting down of the subsidy and further cutbacks in Medicaid and Medicare, and the Public Health Initiatives.

Other Issues

Other issues that need to be addressed by this Committee relate to some of the areas that the Administration often praises as its rural policy. For example Administration representatives talk about the incentives to providers to choose rural practice. These include tax credits, limited financial incentives, and the opportunity to work in a

network and have telecommunications access to back up.

There is too much micromanagement of these initiatives in the Legislation. For example Title IV Medicare and Medicaid, Subtitle A, Section 4042, (f)(4) Physician Recruitment describes certain financial incentives in Medicare reimbursements to providers recruited to rural areas, HPSA's or MUP's. This sounded good to me at first but then I read that these incentives are only available to a physician practicing for less than one year or who has moved their practice more than 100 miles from their previous practice and 85 percent of their total revenues must be from new patients, not seen at their previous practice. In a well-intended effort to prevent gaming the system, these restrictions inhibit a rural community from recruiting any willing provider. These reimbursement incentives are not permanent and last only three years. Rural communities need permanent financial incentives to retain providers.

We hear about expansions in the National Health Service Corps. Yet this very day, there is a freeze on the Corps and none of us can fill even our current Critical Vacancies. La Clinica del Pueblo just this month lost a match with a physician assistant due to the freeze, despite having the position listed as a Critical Vacancy.

This is an example of why you will hear skepticism about health reform from rural communities.

Health Reform Must Pass Congress in 1994

Yet, we need health reform and we need it now. I am here today and will be working on this issue throughout the Congressional debate. The Health Security Act needs numerous amendments, some of which I have proposed and others that you will hear about as the debate continues. The National Rural Health Association identified universal access as its first Necessary Component - if we can achieve that, we can continue to work on the details. We thank you for this opportunity to raise some of our concerns. I look forward to working with you to pass comprehensive health reform legislation - for all Americans - no later than 1994.

The National Rural Health Association's Necessary Components for National Health Reform

1. Universal Access

Any national health plan must ensure universal access to comprehensive health care without financial barriers.

Policy Goals/Action Strategies

- Any public, private, or mixed financing mechanism should cover all U.S. residents, and premiums, if levied, should be based on the ability to pay.
- In the event a mixed financing model is adopted, all persons not covered through a private plan would be entitled to coverage in a public plan based on their ability to pay. Persons at or below the federal poverty level would be fully subsidized.
- Federal costs associated with extending health care coverage to all U.S. residents should be financed through broad-based, progressive tax mechanisms.
- Self-employed workers should receive a federal and state tax deduction for 100 percent of premium costs associated with the purchase of private health insurance.
- In the event that private employer-based insurance is expanded and/or reformed, premium costs should be shared by employers and employees; low income workers should receive subsidies for their share of the premium; and employees with earnings at or below the federal poverty level should have their premiums fully subsidized.
- In the event that private employer-based insurance is expanded, the costs of deductibles, co-payments and other out-of-pocket costs should be based on an employee's income and family size. Low income workers should receive subsidies for their cost-sharing responsibilities, and employees with earnings at or below the federal poverty level should be exempt from these cost-sharing mechanisms.

2. Federal Leadership

The federal government must assert leadership in the development and financing of a national health plan.

Policy Goals/Action Strategies

- The federal government should set minimum eligibility and coverage standards to which states and private insurers would be required to adhere.
- The federal government should be responsible for setting annual spending limits and establishing equitable reimbursement policies for provider reimbursement under all publicly financed programs (i.e., Medicare, Medicaid, etc.).
- The federal government should be responsible for establish-

ing uniform administrative and claims processing systems to simplify and streamline the administration of health care financing and delivery.

- The federal government should ensure the portability of public health care financing, benefits and access across state jurisdictional boundaries, as well as the portability of private coverage across employer-based plans.

3. State and Local Self-determination

Any national health plan should ensure that state and locally determined community needs and preferences are addressed in the design, development and maintenance of local health care systems. This decentralized approach should include local planning, collaboration, coordination and evaluation efforts.

Policy Goals/Action Strategies

- Any national health policy reform legislation should include state and local representatives from rural areas on program transition teams, blue ribbon commissions, policy advisory councils, etc.
- National health policy reform strategies that expand access, particularly in rural and medically underserved areas, should require community representation and involvement in local planning and development efforts.
- Any efforts to promote managed care or case management systems should be flexible and recognize the unique barriers and system development challenges created by geography and other limitations inherent to rural areas.
- Within federal guidelines, states should ensure the equitable distribution of health care resources and equal access to care for all state residents.

4. Community Development

National health plan proposals should encourage the development of local health care systems that are comprehensive in scope and promote the building of local economic and social infrastructures (including jobs, housing, sanitation, schools, etc.).

Policy Goals/Action Strategies

- National health policy reforms should include federal fiscal incentives to states and local communities to integrate categorical programs across program jurisdictions (e.g., housing, economic development, employment and training, education, maternal and child health, and public health) to maintain and build strong rural communities.

5. Consumer Choice

National health plan reform proposals should contain assurances of consumer choice in terms of financing intermediaries and providers of care.

Policy Goals/Action Strategies

- Any national health plan should provide for multiple delivery system options (e.g., health maintenance organizations (HMOs), preferred provider organizations (PPOs), private practices, community clinics) based on unique population characteristics, geography and consumer choice. Federal guidelines should provide the necessary flexibility to ensure that consumer choice will be protected.

6. Financing Incentives

The federal government should establish a range of provider payment and systems development mechanisms that is flexible so that incentives, exceptions and adjustments to provider payments reflect state and local needs and system capacity constraints.

Implementing national health reforms and establishing health care spending limits, if necessary, must be done to protect programs that support the expansion and development of systems capacity in underserved areas and for underserved populations. Therefore, the capacity to redirect resources within the system must be included in any national health reform proposal. To achieve comprehensive, accessible rural health care delivery systems, the federal government should establish a systems capacity-building program based on the following action strategies.

Policy Goals/Action Strategies

- Federal policy should establish a range of provider payment mechanisms (e.g., capitation, negotiated fees) that would promote cost efficiency and at the same time respect local delivery system constraints (disproportionate share hospitals, sole provider status, geographic barriers, etc.), leaving the establishment of payment mechanisms to the states.
- Federal regulations governing public health care programs (e.g., Medicare, Medicaid and/or an alternative public programs) should provide incentives for the expansion of care coordination services that link and coordinate primary care, mental health and other health services (e.g., long-term care) in rural areas.
- Federal funding should be provided for the expansion of rural health outreach programs to ensure access to care for all eligible residents.
- Federal guidelines should establish standards for the direct reimbursement of nurse practitioners, certified nurse midwives, physician assistants, social workers, mental health professionals, and other licensed providers who practice in health professional shortage areas or medically underserved areas. All payers (public and private) should be required to reimburse these health care practitioners under specified protocols.
- Federal funding for community health centers, migrant health clinics, and other innovative delivery system models appropriate to rural underserved areas should be significantly increased to ensure the adequate distribution of appropriate

and quality health care services.

- Federal financial incentives should be made available to states to assist in the development of comprehensive rural health care delivery systems.
- Federal funding and expansion of rural hospital stabilization programs such as rural hospital transition grants, the Essential Access Community Hospital program (with needed modifications to reimbursement, inpatient day limits and maximum acute care bed capacity), and the Rural Primary Care Hospital program should be increased.

7. Education and Training

Any national health plan should provide policy direction and funding for the education and training of a sufficient number and mix of appropriate health care providers to meet the personnel needs that exist in medically underserved areas.

Policy Goals/Action Strategies

- The federal government should significantly expand programs and increase funding for health care personnel training programs including the National Health Services Corps, area health education centers, and interdisciplinary training grants. Included in this expansion should be scholarships to support nurse practitioners, physician assistants, certified nurse midwives, social workers and mental health workers.
- The federal government should set graduate medical school education standards, which are enforced through the medical education funding pass-through in Medicare, requiring that a minimum number of family practice (primary care) residencies and fellowships be filled each year based on the calculation of need for these slots.
- The federal government should adopt financing incentives that encourage ambulatory training experiences in rural areas.

8. Quality and Efficiency

Any national health plan should have quality assurance systems and accountability mechanisms that ensure continuous re-examination of and improvement in health care service delivery.

Policy Goals/Action Strategies

- The federal government should increase its funding for research of medical and health outcome studies. Additionally, it should increase funding for rural health demonstration projects that test new and innovative models of service delivery in rural areas.
- The federal government should assume a leadership role in the establishment of goals for managed care, utilization review, pre-admission screening, and other systems accountability and quality assurance mechanisms. It should provide states flexibility in determining quality assurance and cost efficiency mechanisms based on the nature of state and local delivery systems.
- The federal government should assume a leadership role in the establishment of national policy regarding the financing and delivery of long-term care services so as to ensure that they are available and accessible to all individuals determined to be in need of such care.

Executive Summary

The subject of health care reform is on everyone's lips. Escalating costs and the increasingly severe problems associated with lack of access to basic health care services for the poor and middle class alike have caused policy-makers in Washington, D.C., and the states to propose far-reaching reforms to the health care system. Many of these targeted reform strategies have been framed and articulated by powerful vested interests who stand to benefit or lose by changes that are made to the existing health care system—changes that include reform of the financing, organization and delivery of health care goods and services. The debate about health care financing and the ensuing reform proposals introduced range from ensuring access to health care as a basic entitlement of citizenship (comparable to public education) to incremental steps that are intended to improve access to health care while preserving the status quo, which is characterized by the buying and selling of health care goods and services in a private competitive marketplace.

The National Rural Health Association (NRHA) is one of many groups concerned about the implications of the various proposals for reform for its membership and primary constituency—rural Americans. Of major concern to the NRHA is that reform strategies recognize the unique access barriers that impede the delivery of health care in rural communities and that they provide the necessary system flexibility and incentives to meet the challenge of these formidable barriers. Access issues in rural America are exacerbated by geography as well as severely depressed economic conditions that have set rural economies apart from metropolitan areas in terms of levels of unemployment and loss of industry during the 1980s.

Necessary Components for National Health Reform

The objective of this paper is to establish a range of necessary components that the NRHA believes to be essential to successful national health reform. This list of components has been adopted by the governing board of the NRHA. They are based on a thoughtful and thorough analysis of the range of reform strategies that have been or are being considered by Congress. The NRHA has not taken a position on a specific proposal or type of reform, but rather has put forth what it considers to be necessary rural considerations that should be embodied in any proposal under debate.

Without consideration of these components, any national health policy reform package will come up short when attempting to ensure proper health care to rural Americans. Once these guiding principles are accepted and employed in planning national health reform, then the policies and regulations built on these principles will better be able to meet the unique health care needs of rural and other Americans.

The National Rural Health Association's Necessary Components for National Health Reform

- 1. Universal Access**
Any national health plan must ensure universal access to comprehensive health care without financial barriers.
- 2. Federal Leadership**
The federal government must assert leadership in the development and financing of a national health plan.
- 3. State and Local Self-determination**
Any national health plan should ensure that state and locally determined community needs and preferences are addressed in the design, development and maintenance of local health care systems. This decentralized approach should include local planning, collaboration, coordination and evaluation efforts.
- 4. Community Development**
National health plan proposals should encourage the development of local health care systems that are comprehensive in scope and promote the building of local economic and social infrastructures (including jobs, housing, sanitation, schools, etc.).
- 5. Consumer Choice**
National health plan reform proposals should contain assurances of consumer choice in terms of financing intermediaries and providers of care.
- 6. Financing Incentives**
The federal government should establish a range of provider payment and systems development mechanisms that is flexible so that incentives, exceptions and adjustments to provider payments reflect state and local needs and system capacity constraints.
- 7. Education and Training**
Any national health plan should provide policy direction and funding for the education and training of a sufficient number and mix of appropriate health care providers to meet the personnel needs that exist in medically underserved areas.
- 8. Quality and Efficiency**
Any national health plan should have quality assurance systems and accountability mechanisms that ensure continuous re-examination of and improvement in health care service delivery.

The Rural Perspective to National Health Policy Reform

Rural Americans are victims of one of our nation's top domestic problems—the lack of access to appropriate, affordable and quality health care services. In spite of romantic notions about rural lifestyles, the geographic and economic challenges of country living have resulted in a population that is disproportionately poor, experiences significantly higher rates of chronic illness and disability, is aging at a faster rate than the nation as a whole, and has a substantial uninsured and underinsured population because many rural workers are self-employed and therefore do not have employer paid or subsidized insurance programs available to them. Given these obstacles, obtaining good health care is a challenge for most rural residents; for others, it just is not possible.

At least 34 million Americans are uninsured and millions more are underinsured. However, even if insurance was made available to all, that would not solve the access issue for rural Americans. Compounding the insurance problem is the constant threat of closure of rural hospitals and clinics, and the shortage of health care professionals who are willing or able to locate and

practice in rural areas. Unless the issues of resource development and capacity building are addressed concurrently with financing reform, the majority of rural Americans will continue to face significant barriers to accessing essential health care services.

Current and Recent National Health Reform Proposals

This study examines 16 health care reform proposals that have been introduced into Congress as well as the proposal prepared by President George Bush's administration, particularly how they address the health concerns of rural Americans. In the Appendix all 17 proposals appear in a side-by-side comparison in "A Comparison of Select National Health Care Reform Proposals." How the proposals score on addressing rural health care issues is assessed in the "National Health Reform Proposal Scorecard," also in the Appendix. Through this process, four types of proposals emerged. They are presented below.

Overall, all of the proposals dealt with some of the rural issues that need to be addressed in health care reform. However, as yet, no one proposal adequately addresses the full myriad of health care issues facing rural Americans.

A Primer on National Health Plan Proposals

When considering current and recent health reform package proposals, four basic approaches to reform have developed—a mixture of market reform combined with expansion of public benefits, pay or play, single payer, and managed competition.

1. Mixed: Market Reform/Expansion of Public Benefits

First put forth by the Health Insurance Association of America (HIAA), this type of proposal is characterized by the idea that the existing model of a private health insurance market within the context of an employer-based insurance system is the most appropriate and realistic approach to health care financing.

These proposals specifically target the small firm employment sector where the largest number of uninsured workers can be found.

Key features of this reform strategy include: federal statutory authority to pre-empt state mandated benefits; annual limits on premium increases for small group employees; not allowing insurers to cancel high-cost policyholders solely because of their medical conditions; insurance for all employees of a group regardless of pre-existing medical conditions; and comparable rates for small groups within a given geographic area and job classification.

2. Pay or Play

This approach to health care reform mandates that employers with more than 25 employees, offer health insurance to their employees. To ensure coverage for those not privately insured, a surcharge would be levied against

employers who do not provide health insurance to their employees. The revenues from this tax would be used to support a public insurance plan to which uninsured workers would be assigned. The public plan would be administered by a government agency.

3. Single Payer

Under the single payer approach, the federal government would finance health care through a universally available plan with revenues from broad-based payroll or income taxes, or both. The single payer model assumes a much diminished role for private insurance, and in several proposals, private insurance would be eliminated completely. Most single payer plans allow individuals to choose among providers and all maintain a private delivery system.

4. Managed Competition

Managed competition, also known as the Enthoven plan, is receiving increased attention from both federal and state policy-makers. The basic tenet of this plan is to establish a competitive health care system that rewards the most efficient health care agencies and providers with the most customers, thereby creating an economic incentive for effective use of health care dollars.

Key elements of this model include: a totally private sector health care system; employer-based coverage; a capped federal tax exclusion for health benefits based on the lowest cost plan in a region; and three private sector boards that would be responsible for developing standards and an independent, quasi-governmental agency to administer the boards.

Mr. WAXMAN. To what extent do you all believe that we need to have a continued Federal role in support of a National Health Service Corps and a system of community health centers or clinics in rural areas after we have health reform fully implemented?

Mr. SPLINTER. I would make one comment on that, that I would hope that the movement in any phase out would go slow, that we have proven results with the changes before we start backing out of our current systems for supporting those programs.

Mr. MORRISSEY. Mr. Chairman, coming from a State that has only three funded community health centers and a very small number of National Health Service Corps placements, partly because of the concerns expressed earlier, it is difficult to say that we can't survive without them.

We are certainly looking at those resources, however, in the future to begin to address the gaps that we have now got and recognize. I would—I guess I don't see in the, even perhaps in the long term, the resources, the human resources particularly necessary being there without those kinds of supports.

Mr. WAXMAN. Ms. Bruce.

Ms. BRUCE. Coming from Michigan, we have a high migrant population, a fair number of undocumented aliens, and the community health centers and migrant programs provide health care to that population largely, so in a minimum, we need a transition plan.

I don't think any of us could sit here today and say that we could do without either the National Health Service Corps or those community health centers until we have an opportunity to see how health reform is really enacted and then how it is implemented.

So I would argue for a very safe transition plan and maintain those until we could have an opportunity to evaluate them.

Mr. WAXMAN. It is probably going to be true if we adopt this plan and don't cover undocumented aliens because they are going to have to go somewhere.

Ms. BRUCE. Absolutely.

Mr. WAXMAN. Ms. Miller.

Ms. MILLER. Yes, I would like to see local health departments and some recognition of public health when we look at essential community providers. I think that the public health initiatives are extraordinarily weak.

I have spoken to Dr. Lee about it and, for example, on the core public health functions which are supposed to monitor the quality of care people are getting under the plans, surveillance of illness, a lot of other things, care for undocumented workers, there is three ten-thousandths of one cent for every dollar that is going to go into medical care. There is no way.

These core public health functions are not mandatory. There is a menu from which States can select. I think we are building the potential here for a real public health crisis by not strengthening the public health infrastructure and recognizing their important role and considering them as essential community providers.

Mr. WAXMAN. Thank you, very much.

Mr. Synar.

Mr. SYNAR. Thank you, Mr. Chairman, and let me thank all the panel for some very insightful information with respect to rural health.

Garth, let me spend some time with you, if I could. How many States are presently developing telemedicine systems, such as the one you described in—

Mr. SPLINTER. It depends on the definition. There are quite a few States that have various projects. Our thought with the Oklahoma telemedicine network is that it is potentially the largest one under way in terms of having the 46 and potentially 66 hospitals on line.

Mr. SYNAR. So we are probably in the forefront of this particular development of telemedicine, correct?

Mr. SPLINTER. I believe so, in terms of actually trying to get out in the field and wire these places up.

Mr. SYNAR. I was just doing some simple arithmetic here. The total grant private and public is \$5.1 million for 46 hospitals, which means you are basically setting up a system at about \$110,000 per hospital. That is a pretty good bang for the buck, isn't it?

Mr. SPLINTER. We have some concern about the total budget. We are getting some assistance from Apple Corporation because of their interest, and so we are receiving some fairly good rates on equipment purchases.

The development of products though is not really included in that, and of course some of the equipment is leased as opposed to purchased.

Mr. SYNAR. But once you have the start-up costs, adding additional hospitals and units is a much cheaper idea. Isn't that safe to assume?

Mr. SPLINTER. Well, with the equipment at each hospital, it is potentially the same cost. The—some of the switching gear and the protocols would all be established, and so those start-up costs would only have to be covered once, and certainly as products are developed, then they are available for use anywhere on the network.

Mr. SYNAR. On the technical area, is it safe to assume that most systems will probably do digital versus video analog?

Mr. SPLINTER. As I was referring to before, there is some question about that. Our thought is that the future needs to be digital for a variety of reasons.

Digital video right now is fairly expensive. It doesn't have quite the resolution quality that would be desired, but our projections are that within two years it will be cost effective and much improved in technology.

The problem is in trying to convince people not to make a major investment in analog TV equipment now which may be a barrier to them changing later. Plus private hospital systems of course are using that as a way to try to capture rural hospitals and link them in. They like the idea of a point to point wiring as opposed to an open network design.

Mr. SYNAR. Let's talk about reimbursement. What is the present telemedicine Medicare reimbursement schedule and does that fit this scheme or do we need a better system?

Mr. SPLINTER. There really is none that I am aware of except for radiology. I am not sure what the amount is. The radiologists at the VA hospital are comfortable with the levels compared to their normal fees for reading x rays.

HCFA was making payments for network consultations in Georgia, but my understanding from talking to some of the HCFA officials is they have had that retracted and they are reviewing the subject now.

Mr. SYNAR. That is a major barrier because interactive consultations are really the area where most people worry that there could be some potential fraud and abuse. How do we avoid that?

Mr. SPLINTER. Well, it may not be any more subject to fraud and abuse than in the current system. So we would apply the same types of things of documentation and periodic audits to prove that the services are being rendered.

Mr. SYNAR. Plus the systems themselves can record the consultation, can't they?

Mr. SPLINTER. If everything is recorded, the storage problems will be immense, but it is possible to try to have—there could be a requirement for small bits to be recorded and saved, and so that is a check that could be built into the system.

Mr. SYNAR. But that presses the point you made in your testimony of the need for HCFA or the agency of jurisdiction to standardize this and basically set rules so that we will know, correct?

Mr. SPLINTER. Yes, sir.

Mr. SYNAR. Thank you, Mr. Chairman.

Mr. WAXMAN. Thank you, Mr. Synar.

Mr. Slattery.

Mr. SLATTERY. I too want to welcome all of you, and Dr. Morrissey, it is good to see you here today and I appreciate the work that you all have done out in Kansas and I think that from what I have gathered, there is a lot of similarities between the efforts being made in Kansas and Oklahoma in terms of telemedicine.

I am just curious, following up on what Mike Synar was asking, where do you see the Federal Government playing a role in this—in the question of standardization? Explain that to me a little bit more clearly, either one of you.

I am just curious what you see the role of the Federal Government being because in Kansas what we have done with our fiber optic networks all over the western part of our State is I think we are light-years ahead of many States, and we will soon have interactive voice video capability, solid fiber network from the University of Kansas Medical Center, for example, and I am just curious. That was done with basically private money, and I am just curious what role does the Federal Government really need to be playing in this if we have State models in the country to really show the rest of the country how in the world to proceed?

I am just curious, where did the money come from in Oklahoma?

Mr. SPLINTER. Most of that money has come from—I believe it was \$3.5 of that \$5.1 came from government monies. The rest from—

Mr. SLATTERY. Was it Federal Government money?

Mr. SPLINTER. It was Federal through the State department of commerce. It was development block grant money from the Department of Housing and Urban Development funded through our department of commerce. The funds for the two smaller projects were oil overcharge money used for that.

And I am not sure where the funding came from in Kansas, but with most of these systems, they have been done more as research or for outreach programs, demonstration programs, even the fairly large ones. The problem of course is that is not self-sustaining.

There has to be payments for services over the network to have it self-sustaining. There is some value of course with C&E and business functions that can be done over it now. When I was talking about Federal standards, I am really talking about reflected through the criteria for payment.

The Health Care Financing Administration is in a very good position to be able to say, we will pay for services over networks if they meet these types of criteria, both for the services rendered and for the quality of the information.

That would set some parameters on the equipment people use and ultimately would lead to the ability of all these State-based networks and different networks within States to talk to each other and cross link so that some services could even be bought at a national level.

Mr. SLATTERY. Mr. Morrissey, do you want to comment on that?

Mr. MORRISSEY. Yes, Mr. Slattery. The situation in Kansas is a little different in that, as you point out, the infrastructure investments were, I think, largely private, the development of the communications technology was funded entirely with private resources.

There may have been some Federal grant funds used in the interactive video systems being established, but those would have been through the individual providers. For example, some of the EACH grant funds probably were used or were used by some of those facilities in getting into the interactive equipment that was necessary, but those were local choices that were made with other kinds of grant funds.

That system does use compression technology which, in fact, is necessary to get it to those locations in the State that don't have the fiber optic capability, and we still have quite a few of those, so it can go both ways.

I think there is—there are still issues with the communications infrastructure that are not resolved in probably most rural States, perhaps not as much in Kansas, although we still have several areas where the technology is such that we can't reach them with some of the systems that are there now and could be used.

I frankly think it is very difficult to define what is the Federal role and the State role in that.

Mr. SLATTERY. That is what I was getting at, because I am really concerned that we don't want to come in and really lay over a layer of Federal bureaucracy here that will have a stifling effect on what is going on right now in the States, because, I mean, our State, Oklahoma, and Iowa has gone ahead and they have pressed ahead as I understand it really using public money to—in excess of \$100 million, I believe, to fund the infrastructure in Iowa.

In our State, we have had in excess of \$100 million over the last four or five years and now Southwestern Bell is committing another \$40 million in infrastructure and improvements to accommodate some of this telemedicine in our State and other telecommunications innovations in the next five years, so I was just curious,

when we were talking about standardizing the equipment, really is that a role for the Federal Government?

Mr. MORRISSEY. I really don't think it is primarily. I think that is also going to happen out of some of the private sector development that is occurring and as with computers, we are going to see more standardization develop as the market demands it, and you can see that process occurring already.

Mr. SLATTERY. My concern is, if we start to put into some sort of Federal regulation or law some specifications for equipment, the technology is just going to outstrip those specifications, so if we are not careful, we will have a break on technology imposed by Federal regulation.

I mean, that is just a concern of mine and I was curious if that was shared by any members of the panel.

Mr. SPLINTER. If I could clarify. I share those types of concerns and what I would like to see is using the purchasing power of HCFA though to go ahead and set criteria that could be met by various equipment and would just pull the systems close enough together that interfaces could be put in place, and of course ultimately having a payment mechanism, and hopefully private payers would pick up on that, that will be what causes this to be self-sustaining.

Mr. SLATTERY. Thanks. I have no further questions, Mr. Chairman. Safe travel back to the heartland.

Mr. WAXMAN. I want to thank the four of you very much for your testimony. I think you have given us an excellent record for the hearing. That concludes our business for today. We stand adjourned.

[Whereupon, at 4:10 p.m., the subcommittee was adjourned, to reconvene at the call of the Chair.]

[The following statements were submitted:]

January 26, 1994

The Honorable Henry Waxman, Chair
Subcommittee on Health and the Environment
Committee on Energy and Commerce
2415 Rayburn House Office Building
Washington, DC 20515

Dear Representative Waxman:

On behalf of the over 77,000 members of the American Academy of Family Physicians, please accept this submission for the record of the hearing of the Energy and Commerce Subcommittee on Health and the Environment held on January 25, 1994. We are privileged to have this opportunity to express our views on the physician workforce issues raised in the *Health Security Act*.

Despite a substantial and sustained investment in physician training by the federal and state governments and the private sector, there is a growing disparity between the product of medical education and the health care needs of society. The emergence of the health system reform movement has highlighted the fact that, in addition to having the highest per capita health care costs, the U.S. health care system has the lowest proportion of generalist physicians in the developed world. The evidence linking excess costs to the extreme over-specialization of the U.S. physician workforce has been corroborated in a number of recent studies. Furthermore, the specialty imbalance is steadily worsening. According to projections recently published by the Council on Graduate Medical Education, without changes in the current physician training pipeline, by the year 2000 there will be a shortage of 35,000 generalist physicians and a surplus of 115,000 specialist physicians. It is eminently clear that if health system reform is to provide universal access to appropriate care within reasonable cost constraints, the proportion of generalist physicians in practice must be substantially expanded.

Over the past few years there has emerged a growing consensus regarding the need to correct the specialty imbalance (currently 30 percent primary care and 70 percent non-primary care) to one in which there is an even balance between primary care and non-primary care. Organizations supporting a one-to-one ratio between generalists and specialists include the American Medical Association, the American College of Physicians, the Council on Graduate Medical Education, the Association of American Medical Colleges, the Physician Payment Review Commission, and others. The existence of a consensus on the need to correct the specialty imbalance is especially important because the efforts to achieve a balance will require



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significant changes in current federal policies and aggressive new interventions. These interventions are controversial because they challenge the status quo, but they are essential if we are to achieve affordable and universal access to comprehensive health benefits.

Provisions in the *Health Security Act*

The mix of physicians currently produced by the U.S. medical education system is a direct reflection of the financial incentives in the federal programs supporting these activities. Specifically, the strong inpatient bias in Medicare's graduate medical education support and Medicare's traditional over-reimbursement of procedural services have powerfully influenced the distribution of the physician workforce toward the procedurally oriented subspecialties. Ironically, while the market for medical care increasingly demands more primary care services, the market facing medical educators continues to provide powerful incentives to produce physicians narrowly trained in subspecialty fields. Changing the specialty mix of the physician workforce will require a reversal in the current incentives and establishing a meaningful connection between the market for medical care and the market for medical education.

The Academy is pleased that provisions of the *Health Reform Act* related to the physician workforce constitute a substantial redirection in current federal graduate medical education (GME) policies. Section 3001 of the *Act* establishes a National Council on Graduate Medical Education within the Department of Health and Human Services. The National Council is required to allocate the designated annual number of specialty positions nationwide among eligible programs on the basis of medical need. At least 55 percent of individuals completing eligible programs must be in primary care (Section 3012). Furthermore, the National Council is required to reduce the total number of residency positions.

Section 3013 of the *Act* requires that the historical distribution of specialty positions among different areas of the country and the quality of each of the programs be included among the factors considered in making allocations among programs. It also provides incentives to increase the number of under-represented minorities in the field of medicine.

With respect to GME funding, approved physician training programs must agree that the number of enrollees in their programs will be in accordance with national goals (Section 3011). The definition of an approved physician training program is expanded to include programs based in ambulatory settings whether or not they also provide inpatient hospital services.

Section 3033 of the *Act* establishes an all-payer health professions workforce account for making payments to eligible programs. Payments are based on the national average of the costs of training residents and will be made directly to the program. In addition, Section 3051 takes into account the short-term strain this shift will place on some subspecialty training centers by authorizing payments to provide transitional support to institutions that lose residency positions.

In addition to the *Act's* provisions related to direct GME support, Medicare's current indirect GME support is replaced by federal formula payments to teaching hospitals and to academic health centers to cover their specialized teaching costs (Sections 3101-3103). These funds would be distributed in proportion to the product of their relative gross receipts for patient care and Medicare's current indirect teaching adjustment. The Secretary is required to report to the Congress by July 1, 1996, with any recommendations for allocating funds among centers. Medicare payments for indirect graduate medical education costs are terminated on October 1, 1995. Funds for the annual academic health center account are to come from Medicare, corporate alliances, and regional alliances.

Section 3071 of the *Act* establishes or strengthens existing programs with respect to training primary care physicians. This new focus will include programs (1) to retrain mid-career physicians previously certified in a non-primary care specialty; (2) to expand the supply of physicians with special training to serve in medically underserved areas; (3) to expand the training of under-represented minorities and disadvantaged persons; (4) to expand service-linked educational networks for training in community settings; (5) to provide training in managed care, practice management, continuous quality improvement, and culturally sensitive care; and (6) to enhance information on primary care workforce issues. These programs are to be carried out through existing programs in Titles VII and VIII of the Public Health Service Act.

We believe that the *Act* contains important and essential reforms for achieving an appropriate balance between generalist and specialist physicians. Except for a few small, categorical programs authorized under Title VII of the Public Health Service Act, the current system of funding physician training is characterized by open-ended financing and a complete abdication of accountability for the expenditure of billions of public dollars. Furthermore, no developed nation has been able to achieve an appropriate supply and specialty mix of physicians without taking a much more prescriptive and targeted approach than is currently taken in the U.S. The physician workforce provisions in the *Health Security Act* are an important step toward achieving this end for our nation.

Definition of primary care

As this committee grapples with strategies for meeting the demand for primary care service, we urge that primary care not be trivialized in the process. The *Act* defines primary care as the specialties of family practice, general internal medicine, general pediatrics, and obstetrics and gynecology. The inclusion of obstetrics and gynecology is contrary to most definitions of primary care and may compromise efforts to address the severe maldistribution of physicians by specialty.

The fact that ob-gyns provide certain services that are within the domain of primary care is well recognized. However, the commonly accepted definition of primary care incorporates a much broader range of skills and knowledge than is present in the practice of most ob-gyns or in their training. As defined by the Council on Graduate Medical Education, primary care

entails first-contact care of persons with undifferentiated illnesses, comprehensive care that is not disease or organ specific, care that is longitudinal in nature, and care that includes the coordination of other health services. In its fullest sense, primary care includes the assessment and evaluation of signs and symptoms initially presented by the patient, the management of acute and chronic medical conditions, the identification and appropriate referral of patients with conditions requiring specialized care, and the provision of health promotion and disease prevention services. While a number of providers receive training in and typically provide some important aspects of primary care, it is only the primary care specialties of family practice, general pediatrics, and general internal medicine that are specifically and fully trained to provide the broad range of primary care competencies. The ob-gyn literature clearly acknowledges the limited role of ob-gyn in the provision of primary care.

As the definition of primary care is used in the *Health Security Act*, it dictates a substantial redistribution of training funds among physician specialties. Because the role of the ob-gyn in primary care is limited, efforts to improve access to primary care will be diluted by including ob-gyn in the definition of primary care. Increasing the training funds for ob-gyn will not substantially improve the number of providers of primary care services. Furthermore, including ob-gyns in the definition of primary care suggests that there are available many more primary care physicians than is, in fact, the case.

It is commonly understood that many women may, by personal preference, choose to obtain the majority of their routine health care from an obstetrician-gynecologist during certain periods of their lives. This is clearly an option that will be preserved under the mandatory fee-for-service plans, and it is expected that many managed care entities will allow women to utilize an ob-gyn routinely. The larger issue is improving access to primary care services. An important part of addressing this issue is training more primary care physicians, which can best be accomplished by leaving undiluted the current definition of primary care (family medicine, general internal medicine, and general pediatrics).

We believe it critically important that the traditional definition of primary care (family medicine, general internal medicine, and general pediatrics) be retained.

Identifying primary care training programs

An issue related to the definition of primary care is the criteria by which primary care residency programs are identified. In order to accurately allocate approved residency positions between primary care and non-primary care specialties, there must be some assurance that graduates of primary care residency programs actually enter primary care practice. A varying proportion of physicians who complete residency training in the primary care specialties elect to subsequently enter subspecialty practice. For family medicine residency graduates this proportion is less than five percent. For internal medicine and pediatrics, the proportion of residency program graduates who elect subspecialty practice ranges from thirty to sixty percent or more.

In order to identify those internal medicine and pediatric residency programs that are dedicated to producing physicians who actually enter primary care practice, the Academy supports a two-pronged approach. The regulatory criteria that are currently employed to identify programs eligible for support under Title VII of the Public Health Service Act are sufficiently stringent that programs identified with these criteria tend to produce a relatively high proportion of primary care physicians. These criteria include faculty experienced in general internal medicine and general pediatrics, selection of trainees who have applied specifically for a generalist program, the use of ambulatory training settings, the provision of continuity of care to a patient population in each year of training, and a planned curriculum emphasizing primary care.

An alternative outcomes criterion would be employed in the case of training programs that do not meet the current Title VII regulatory criteria. Training programs would be eligible for designation as a primary care program if over a three year period an average of 80 percent of its graduates have entered primary care practice three years after completing residency training.

Composition of National Council on Graduate Medical Education

Section 3001 of the *Act* specifies that the membership of the National Council on Graduate Medical Education be representative of consumers, medical school faculty, physicians in private practice, health alliances and health plans. Curiously, in a council that is devoted to overseeing graduate medical education, there is no requirement for representation from physicians who are faculty in residency programs. We strongly recommend that faculty members of generalist residency programs be specified for membership on the National Council in lieu of faculty members of medical schools.

Cap on aggregate number of training slots

Section 3012 of the *Act* requires the National Council to ensure that the total number of residency positions be reduced to a number that bears a relationship to the number of graduates of U.S. medical schools and takes into consideration the need for additional physicians. Implicit in this provision is a broad consensus on an aggregate surplus of physicians in the U.S. The U.S. Bureau of Health Professions projects an overall surplus of 80,000 physicians by the year 2000, rising to a surplus of 200,000 by the year 2020.

Due to the long length of the physician training pipeline, any limit on the number of residency positions will not have a perceptible impact on the physician supply for well over a decade. Because of the size of the physician surplus, the Academy believes that the *Health Security Act* should specify a tighter limit on the number of first year residency slots than is currently provided. Specifically, there should be established an initial limit on the number of first-year allopathic and osteopathic residency positions of no more than 110 percent of the number of 1993 U.S. allopathic and osteopathic medical school graduates. As part of its on-going duties the National Council on Graduate Medical Education should develop and

propose recommendations to revise the limit on residency slots by the year 2000. This recommendation is consistent with one recently proposed by COGME. The change lies in fixing the aggregate number rather than letting it float based on the number of graduates produced by the medical schools. According to COGME, it would reduce the number of approved positions from 24,000 to 19,000, and would result in a leveling of the growth of the physician supply relative to population by 2010.

Support for ambulatory and primary care training

The Academy believes that graduate medical education funding must be revised in a manner that recognizes the changing realities of medical practice. An increasing proportion of medical care is now delivered in the ambulatory setting. As a result, inpatient hospital utilization has steadily declined. In contrast, current GME funding is, for all practical purposes, only available to inpatient institutions and provides powerful incentives to focus on training in inpatient care. If the U.S. physician workforce is to be responsive to actual health care needs, the health system must provide substantially greater support to ambulatory training. In this regard, the workforce provisions of the *Health Security Act* are a good start, but they could be substantially improved.

As noted above, the *Health Security Act* proposes to establish an all-payer GME fund based on a national average per-resident training cost. Currently, Medicare direct GME payments are based on cost reports submitted by each sponsoring institution, and per residents amounts range widely from approximately \$10,000 per year to well over \$100,000 per year. Establishing a national average per resident cost helps address this unjustifiably wide variation in direct GME payments. However, training in the ambulatory setting is substantially more expensive than training in the inpatient setting. We are concerned that payments based on average per-resident training costs will be inadequate to support residency programs that contain a large ambulatory component. Typically, it is the primary care specialties that emphasize ambulatory training.

Our concern regarding inadequate direct GME payments based on a national average per-resident amount is heightened by the *Act's* provision related to indirect payments. As noted above, support for indirect teaching costs will continue to be funneled exclusively through inpatient facilities and will do little to support the ambulatory training of primary care physicians.

In order to adequately fund ambulatory and primary care training, it will be necessary to direct a larger proportion of the GME funding in the *Health Security Act* to programs in the primary care specialties. The Academy recommends that Section 3033 be amended so as to up-weight direct payments to primary care residency programs by a factor of two. Payments to programs in the non-primary care specialties would be adjusted to achieve budget neutrality.

Consortia

Section 3013 of the *Health Security Act* requires the National Council on Graduate Medical Education to allocate the designated annual number of specialty positions nationwide among eligible training programs. We believe that after setting national goals related to the aggregate number of training positions and the primary care - non-primary care mix of specialties, the actual allocation of approved positions to training programs should be accomplished through a more decentralized process. Specifically, the Academy supports the allocation of residency positions to be funded and the distribution of GME training funds through regional or state training consortia operating within broad national goals related to the aggregate number and specialty mix of training positions. GME training funds should be distributed to the legal entity sponsoring the residency program. This approach would provide for more private sector involvement and would be more sensitive to local needs.

Each consortium should be a non-profit entity broadly composed of all institutions in the region or state that legally sponsor residency training programs. Other institutions with an interest in graduate medical education, such as medical schools, may serve the consortia in an advisory capacity. Each consortium should be governed by a board of directors elected by the members of the consortium.

In regard to the specific role of medical schools in consortia, we note that only one-third of family practice residency programs are administered by medical schools. Many medical school environments socialize medical students away from career interests in family practice. However, since medical schools will need to prepare students for career choices in available residency positions, it is important that medical schools be involved in consortia activities.

Two or more consortia should be allowed to enter into negotiations regarding the distribution of residency positions such that the aggregate number and specialty mix conform with national goals specified by National Council on Graduate Medical Education. However, no consortium should have less than 40 percent of its approved residency positions in the primary care specialties of family medicine, general internal medicine, and general pediatrics. This recommendation provides some limited flexibility in meeting the national goal of 50 percent primary care. However, it establishes a floor of 40 percent, below which no consortium can fall. This floor is established to emphasize the shift to a primary care-based model of health care delivery in all areas of the country, and the necessity for all medical education and training institutions to be directly involved in meeting the public's need for primary care physicians.

Within the limitations set by the *Act*, the National Council on Graduate Medical Education sets national goals related to the aggregate number of residency positions and the minimum percentage of positions in the primary care specialties. Except as noted below, consortia would approve residency positions in a manner that is consistent with national goals and responsive to the need for medical care within the state or region. NCOGME should review consortia decisions related to the specific number and specialty mix of approved residency

positions for conformance to national goals. In addition, NCOGME may modify national goals related to specific specialties that remain in under- or over-supply. This provision recognizes that in certain very narrow specialties, training programs prepare graduates for a national rather than regional market. It establishes a mechanism to address a situation wherein the aggregate decisions of all consortia fail to address current or projected shortages of physicians in specific specialties. For example, it may be that in the aggregate consortia fail to provide for a sufficient number of training positions in preventive medicine or child psychiatry. NCOGME should be able to make specific modifications in national goals and negotiate with specific consortia to ensure that such shortages are addressed.

Support for faculty development

The vast majority of family practice residency program graduates enter clinical practice. Consequently, a major impediment to the expansion of family practice residency programs is a shortage of trained and experienced faculty. The Academy believes that among the related programs established in Section 3071 should be a substantial expansion in the funds available for primary care faculty development. This is a critical variable in successfully accomplishing the goal of increasing the production of family physicians.

Primary care research

In Sections 3201 and 3202, the *Health Security Act* establishes new health research initiatives in health promotion and disease prevention and health services research. While these are important, the *Act* omits a highly relevant and to date largely ignored area of primary care research.

For the past 30 years, over 95 percent of all medical conditions have been evaluated and treated outside of hospitals. However, the traditional focus of medical education and research has been on medical problems in referred and hospitalized patients. Thus, the training of physicians and the research agenda have focused almost exclusively on inpatient rather than outpatient evaluation and treatment.

The National Institutes of Health and the Agency for Health Care Policy and Research have given only the most limited attention to primary care research. A Section 3203 should be added to specify a third focus for new funding for research in primary care, which is defined as research related to better assisting the generalist physician in diagnosis and treatment of the undifferentiated patient population treated in the ambulatory care setting.

Priority areas for primary care research should include:

- Research to better understand the role of diagnosis in family practice and primary care so as to assist the generalist physician with evaluating the myriad symptoms of the patient, differentiating self-limited diseases from those requiring ongoing or intensive treatment and initiating effective treatment. The tangible benefits of such

research could streamline the diagnostic process, increase accuracy, and reduce the use of expensive and potentially dangerous medical tests.

- Research to improve the effectiveness of medical care as the physician, in collaboration with the patient, designs and implements an effective treatment that reconciles the idiosyncracies, preferences and the needs of the patient with the realities of the illness.
- Research to improve access to health care and the cost-effectiveness of care focusing on the role of frontline, generalist physicians.

Physician retraining

There is a clear consensus on the need to train more generalist physicians as well as to provide incentives for more medical students to choose generalist careers. We believe that priority must be given to the support of generalist graduate medical education programs and those elements of the undergraduate medical school environment that influence student career choices. However, the large pool of excess subspecialty physicians, if provided with appropriate training in the primary care competencies, constitutes another potential short-term solution to the shortage of generalist physicians.

Few models for physician "retraining" currently exist. Short, continuing medical education programs provide little quality assurance and no generally accepted measures of competence. Longer, GME programs, at the other extreme, lead to board certification, but take a minimum of two to three years and are oriented toward recent medical school graduates rather than to limited specialists who seek retraining.

A host of retraining issues remain unresolved. Are there alternative retraining models shorter than full board certification, but with more assurance of competence than continuing medical education courses? Can limited specialists be retrained into generalists on a part-time basis in less than two years while maintaining an income sufficient to meet personal financial obligations? What are the primary care competencies that should be taught to such a group? How can appropriate candidates for retraining be identified and how can their individual educational needs be addressed? How much demand will there be from limited subspecialists to undertake retraining? Given the chronic shortage of family practice residency program faculty, who will be available to teach retrainees? By what processes will the competency of retrainees be evaluated? Will retrainees be eligible for board certification?

Based on the relatively limited data that exist on physician retraining, the Academy recently developed the following recommendations.

First, family practice residency training leading to board certification should be promoted as the prototype model for training physicians seeking skills in primary care. Second, flexible

part-time models of residency training should be developed and promoted. Third, new curricular models geared to meeting the individual training needs of physicians entering family practice residency education should be developed and encouraged. Fourth, managed care delivery systems should be encouraged to develop flexible and part-time retraining models within family practice residency programs.

Fifth, the capacities of family practice residencies should be expanded with added resources to provide focused primary care educational opportunities for physicians that do not lead to board certification. This model of "on-the-job" continuing medical education may be through short courses (mini-residencies) or longer part-time programs.

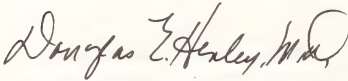
Sixth, federal GME support should be available for all residents enrolled in family practice residency programs, regardless of previous training. Seventh, the Public Health Service should support demonstration projects in physician retraining with funds in addition to those already committed to the training of physicians through Title VII.

Finally, HMOs and other managed care organizations should be encouraged to develop family practice residency programs.

Conclusion

We appreciate the opportunity afforded us by the committee to comment on the physician workforce issues in the *Health Security Act*. It is not possible for us to emphasize strongly enough that workforce reforms are essential to the success of health system reform, no matter what your vision of health reform might be. We look forward to working with the Congress in addressing these and many other important health care issues.

Sincerely,



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January 21, 1994

TO: Mike Hash
FROM: Graham Newson
Karen M. Hendricks
RE: PEDIATRIC WORKFORCE STATEMENTS

Attached please find a copy of two documents related to primary care and pediatric workforce issues. Per your suggestion, we are submitting these documents for the record of the upcoming hearing on workforce issues. The first is a policy statement recently published in Pediatrics, the Academy's professional journal. This statement outlines our position on Pediatric Workforce including several recommendations. The second document is a statement on GME and Pediatric Workforce Principles which reflects the consensus of the academic and practicing pediatric community -- the Federation of Pediatric Organizations.

If you have any questions please do not hesitate to call. We hope that we will have an opportunity to discuss this issue further with you following the hearing.

AMERICAN ACADEMY OF PEDIATRICS

Pediatric Workforce Statement

Committee on Careers and Opportunities

Developing accurate forecasts for physician workforce needs is an extraordinarily difficult task. In 1980 the Graduate Medical Education National Advisory Committee (GMENAC) completed a comprehensive workforce study. Based on estimates of growth of the number of pediatricians, GMENAC predicted a potential excess of 4950 pediatricians by 1990.¹ The American Academy of Pediatrics (AAP) studied the report and issued a response in 1981 that questioned many elements in the model.² However, the Academy was concerned that an excess number of pediatricians would be produced by the 1990s, and a statement published in 1985 and revised in 1987 recommended government and academic policies ensuring the production of pediatricians of the highest quality, but in fewer numbers.³

Subsequent to the 1987 statement, consistent evidence has pointed to shortages of pediatricians rather than the projected surplus in all regions of the country. A 1990 survey of residency program directors provided the strongest empirical evidence to date that the supply of new pediatricians is not meeting the demand.⁴

In 1990, the Council on Graduate Medical Education (COGME) contracted with the consulting firm of Abt Associates, Inc to reexamine the adequacy of physician workforce supply. The resulting report, commonly referred to as the Abt report, contends there would be an even greater oversupply of pediatricians than projected in the 1980 GMENAC report.⁵ The AAP concerns with this report's methodology and conclusions were strongly voiced to the COGME and in the literature.^{6,7} Subsequent to the Abt Report, the COGME published a report which emphasizes a growing shortage of practicing generalists (ie, general pediatricians, general internists, and family physicians) and calls for an increase in the percentage of residents who complete a 3-year training program in the generalist specialties.⁸

Given the conflicting assessments of the pediatric workforce situation, and persistent misconceptions about an oversupply of pediatricians, it is appropriate that the Academy issue a current statement on pediatric workforce.

PEDIATRIC WORKFORCE

Trends in Pediatric Workforce Supply

According to the most recent data collected by the American Medical Association (AMA), in 1992 there

were 44 881 self-designated pediatricians (both board-certified and non-board-certified) in the United States. The main professional activity of more than 90% of these pediatricians was the provision of patient care in office and hospital-based settings. The remainder were engaged in other professional activities, such as administration, medical teaching, or research.⁹

In 1992, 28% of all pediatricians were younger than 35 years of age, and another 35% were between the ages of 35 and 44 years, which makes pediatricians, on average, younger than other physicians.⁹

A noteworthy trend in the pediatric workforce is the growing number of women entering the specialty. Since 1970, pediatricians has been on the leading edge of the increase in numbers of women in medicine. In 1992, 40% of all pediatricians were women, compared with approximately 21% of all physicians in internal medicine and 18% of all physicians.⁹

The number of international medical graduates (IMGs) in pediatrics has tripled since 1970. IMGs now comprise 29% of the pediatrician population, compared with 22% of the total physician population.⁹ The immigration status of IMGs, along with fluctuations in the US birthrate, variations in practice patterns, and health care reform (discussed in following sections), are four factors that are likely to have the most impact on future pediatric workforce projections.

Pediatricians in Training

Approximately 6200 pediatricians are in residency at any one time.¹⁰ Additionally, more than 1000 fellows are in subspecialty training.¹¹ Currently there are 215 accredited US pediatric training programs. Of pediatric residents 56% are women, and 32% of pediatric residents are IMGs.^{10,12}

During the past several years, interest in primary care specialties has declined among US medical students. However, unlike the other primary care specialties, pediatrics has not experienced a dramatic decline in the percentage of US medical students choosing pediatric residency programs.¹³ This is due in part to the large number of women selecting pediatric residencies.

For the past 8 years, approximately 10% of US medical school graduates matched in the National Resident Matching Program (NRMP) have chosen pediatrics.¹³ In 1993, 10.5% of matching US medical school graduates (1361) matched 66.5% of the pediatric PGY-1 slots (2046) offered through the NRMP.¹³ Foreign graduates filled 17.3% of these slots, and 62

positions were filled by graduates of Canadian schools, doctors of osteopathy, and 5th Pathway students.¹³ A significant number of the remaining pediatric positions are filled outside of the match by IMGs. This has workforce implications for pediatrics, because the immigration status of IMGs is difficult to predict.

Residency programs are federally supported by direct medical education grants based on the number of residents and per resident costs, and indirect medical education support which adjusts Medicare payments in recognition of higher costs of patient care in teaching institutions. Additional primary care grants are provided through the Title VII program.

The future funding of graduate medical education (GME) will have serious implications for pediatrics. In its first report in 1988, the COGME concluded that GME funding was eroding, and that substitute sources were not developing to take the place of patient care reimbursements.¹⁴ Consequently, the American Academy of Pediatrics believes that federal grant support (including the Title VII program) is vital to all primary care GME, including pediatrics.¹⁵ Furthermore, the Academy believes it is critical to insist on the inclusion of pediatrics and pediatric training programs in all primary care incentive programs.

With the significant increase in the number of women in pediatrics, and with the increase of dual-career marriages, life-style and child-rearing considerations greatly influence employment decisions of both women and men. Data from the American Medical Association's 1988 annual survey indicate that, on average, women in pediatrics devoted about 87% as many hours per week to medical practice and saw about 78% as many patients per year as did their male counterparts.¹⁶ In light of the fact that a majority of current pediatric residents are women, we fully anticipate a decline in the mean number of patients seen per year by pediatricians. Any attempt to project future numbers of pediatricians must adjust for this factor.

Another point to consider when examining the pediatric workforce is the fact that 32% of pediatric residency positions are currently filled by IMGs.¹² More than one fourth of IMGs are "exchange visitors" and must return to their countries after training is completed, decreasing the number of pediatricians entering practice after training in the United States.¹⁰

The Academy has determined that the following factors are key issues that must be considered when developing pediatric workforce policy: utilization, provision of care by other providers, pediatric subspecialization, ethnic composition, indebtedness, geographic distribution, and reimbursement.

KEY FACTORS INFLUENCING PEDIATRIC WORKFORCE

Utilization

Contrary to earlier predictions, research reveals a growing, rather than a diminishing market for pediatricians. In a study published in *Pediatrics*, residency directors report a 96% placement rate in 1990, a year widely predicted to be one of "pediatrician

glut."¹⁷ Furthermore, there are indications of an even greater demand for pediatricians in the future. For example, the US Census Bureau predicted that there would be 3.7 million live births in 1990, when the actual number of live births was 4.2 million.^{5,17} The Bureau also predicted that by the year 2000 there would be 66 million children younger than 18 years.¹⁸ Fluctuations in the pediatric population have a great impact on workforce needs and must be factored into workforce models.

Trends indicate that utilization of pediatricians has increased and will continue to increase in the future. For example, data from the National Ambulatory Medical Care Survey (NAMCS) reveal that of the 13 largest specialties, pediatrics was the only specialty showing a significant increase in percentage of all office visits between 1985 and 1989, from 11.4% to 12.6%.¹⁹ During the 12-month period from March 1989 to March 1990, visits to pediatricians accounted for 87.4 million of the 692.7 million ambulatory care office visits made to physicians in the United States.¹⁹ One possible explanation for increased visits to pediatricians is the increase in the number of children enrolled in Medicaid and managed health care plans, both of which generally cover ambulatory care services more than traditional indemnity plans.

Another explanation for increased visits is the fact that pediatricians are increasingly providing health services to all children, especially adolescents from 14 to 21 years of age.²⁰ According to AAP policy, the scope of pediatrics includes infants, children, adolescents, and young adults. In many settings (eg, college health centers, centers for treatment of chronic illness), pediatricians actively participate in the care of young adults beyond the age of 21 years. Successfully addressing the needs of adolescents will continue to affect pediatric workforce needs, as only 24% of adolescent care is now delivered by pediatricians.²⁰

The Academy believes that the need for pediatricians will increase, due in part to the growth of new morbidities such as acquired immunodeficiency syndrome, behavioral and learning problems, divorce, family violence, and child abuse; the medical needs of an increasing population of homeless children, currently estimated to number a half a million plus; and the abuse of tobacco, alcohol, and other substances. Furthermore, the increasing public and governmental concerns about the large numbers of uninsured and underinsured Americans may soon lead to passage of a national health policy, addressing the presently unmet health care needs of children. Enactment of such legislation would help eliminate the financial barriers to needed health care for a great number of children, generating an increase in pediatric contacts ranging from an estimated 5% (Lewin/ICF study commissioned by the American Academy of Pediatrics) to 15%.²¹ The Academy believes that the development of accurate physician workforce models must take these issues into account.

Other Health Care Providers

Allied Health Professionals. Past workforce models have assumed that pediatric nurse practitioners

(PNPs) could deliver from 15%¹ to 33%⁵ of health care services to children. However, for a number of reasons, the rate at which care is delegated is believed to be much lower than that. There are an estimated 6000 active PNPs in the United States, and this total has been relatively constant for the past 10 years.⁶ Furthermore, although PNPs are frequently suggested as lower cost replacements for pediatricians, they are often a comparable rather than a lower cost option due to increasing PNP salaries, limited working hours, fewer patients seen per hour as compared with physicians, and the need for supervision by physicians. The PNPs function well with assigned protocols but are not trained in differential diagnosis and treatment of a broad spectrum of pediatric problems. Therefore, the Academy believes that PNPs function most effectively in teams directed by pediatricians.

Family Practitioners. In the past, physician workforce studies have estimated that about 15%⁷ to 25%²² of services to children are delivered by family practitioners and in rural areas this percent may be higher. However, pediatricians continue to treat the largest percentage of children in the infant and preschool age groups.¹⁹ Moreover, in the past a significant number of older children and adolescents have received care from family practitioners, but pediatricians are increasingly being consulted and recognized as the primary health care experts for these age groups as well.²³

Pediatric Subspecialization

In recent years, both the number of pediatric subspecialties and the number of pediatricians in subspecialties have grown. Currently, there are twelve certificate subspecialties, and the certification of additional subspecialties is expected.²³ Some pediatric subspecialty training—such as general ambulatory, adolescent, and developmental pediatric—*is* often undertaken to enhance the pediatrician's ability to provide optimal primary care services. Many pediatricians take 1 or 2 years of subspecialty training and then enter primary care practice. Others specialize in highly technical areas and care for children with complex diseases. Fortunately, the life-span of many of these children is lengthening, thereby increasing the need for subspecialty care. The Academy believes that all children with complex diseases should have a primary care pediatrician, as well as available and appropriate consultations with pediatric subspecialists.

Pediatrics has shared in the increase in technology available for diagnosis and management of patients, much of which requires subspecialty training. Currently, more than 50% of all pediatric subspecialists are pediatric allergists or neonatologists. Many full-time pediatric subspecialists such as cardiologists, neonatologists, hematology/oncologists, endocrinologists, and nephrologists are almost exclusively employed in medical schools or teaching hospitals and have limited private practices. Despite this fact, many teaching institutions are experiencing an undersupply of pediatric faculty in the basic and clinical sciences.¹⁰

Although some have predicted an oversupply of neonatologists and pediatric allergists, the Academy cannot accurately predict the need for pediatric subspecialists. This is because the increased demand for subspecialists due to the new morbidities faced by children today points to a continuing need for pediatricians in both primary care and subspecialty practice.

Ethnic Composition

Except for Asian physicians, minorities are markedly underrepresented in all specialties including pediatrics. According to the AAP Department of Research, 2.7% of all pediatricians are black, non-Hispanic; 0.1% are American Indian or Alaskan Native; 15.7% are Asian or Pacific Islander; and 5.3% are Hispanic, compared with 75.9% who are white, non-Hispanic. (These figures are approximations based on the 1991 AMA Physician Masterfile and do not include residents.) The number of black pediatric residents increased between 1978 and 1990 (from 274 to 363),²⁴ but the growth remains slow and the total numbers low.

The widening disparity in the health status between nonminority children and minority children has received considerable attention during the past few years. In fact, many of the US Public Health Service's "Healthy People 2000 Objectives" are intended to address the high concentration of disease and disability among racial and ethnic minority populations.²⁵ Minority children are found to have less access to health care, independent of their health status, sex, economic status, health insurance status, and place of residence.²⁶

Increasing the number of minority health care providers has the potential to increase minority populations' access, thereby offsetting some of the difficulties that minorities have experienced in obtaining adequate health care.²⁷ Minority physicians are more likely to be more sensitive to the culture of their minority patients and to practice in underserved areas, thereby having the potential to deliver health care services more effectively.^{28,29} Furthermore, minority pediatricians have a unique opportunity to serve as role models, influencing children and adolescents to choose careers in medicine. The Academy therefore supports the implementation of methods ensuring that more minority medical students choose primary care pediatrics. Furthermore, the Academy believes that barriers such as medical student indebtedness, which is significantly higher for minority medical students,³⁰ must receive immediate attention. The American Academy of Pediatrics believes that more minority pediatricians will not in itself solve the problem of lack of access to care for minority children; however, more caring, concerned physicians who are involved in primary care and providing health care for minority infants and children can affect the health status of minorities.³¹

Indebtedness

Several studies examining the impact of indebtedness on medical students' choice of specialty have produced conflicting results.³²⁻³⁴ However, studies

have indicated that indebtedness is an important issue as perceived by medical students in specialty selection.^{31,35} According to a recent survey of residents conducted by the Association of American Medical Colleges (AAMC) (1987 through 1990), 80% of the respondents were in debt, and the average debt was \$41 000.³¹ In fact, in 1990 the AAMC reported that an accumulated debt of \$75 000 is typical for 11% of medical school graduates.³¹

The Academy is concerned that indebtedness is quite likely to be a contributing factor influencing medical students and residents to choose higher paying specialties and subspecialties at the expense of all primary care specialties, including pediatrics. Furthermore, the Academy is also concerned with the disproportionate impact that indebtedness may have on efforts to increase the number of minorities in medicine. Addressing the complex issue of medical student indebtedness through loan repayment/forgiveness programs is one avenue that the Academy believes must be pursued if pediatrics is going to be able to maintain and enhance its ability to attract medical students of the highest caliber into the specialty.

Geographic Distribution of Pediatricians

The variability in the geographic distribution of general pediatricians needs to be factored into any analysis of pediatric workforce. Although the total number of pediatricians has been steadily increasing, a shortage of pediatricians remains in rural areas and impoverished urban areas. There are several barriers that must be overcome to encourage the location of pediatric practices in underserved areas. The most obvious is financial viability with respect to the often limited child population in rural areas, and the large uninsured or Medicaid-insured populations in both rural and urban underserved areas. Other disincentives include life-style considerations, including social, cultural, and educational opportunities, and the availability of medical resources, eg, location of hospital facilities, access to continuing medical education, coverage respite, proximity of medical colleagues, career opportunities for spouses.

The Academy supports financial incentives at both the state and national levels to attract and retain pediatricians in underserved areas. This should be a multifaceted approach that considers issues such as expansion of the National Health Service Corps, other loan forgiveness programs, financial incentives and reimbursement differentials in Medicaid, and other publicly financed care.

Reimbursement

Pediatricians have historically earned incomes approximately 25% less than the average income of all physicians.^{36,37} However, data from the last several years indicate that this income gap is being reduced, a trend not experienced by other primary care specialties.³⁸

Lower incomes among pediatricians are mainly a result of the inadequate health insurance status of their patients. According to the Employee Benefit Research Institute, 11.8 million children younger

than 21 years of age were uninsured in 1991.³⁹ Furthermore, a great proportion of children are underinsured because many insurance companies do not provide coverage for preventive care or services needed by chronically ill children.

A major source of insurance for children is the Medicaid program. In 1991, nearly 14 million children received Medicaid benefits.⁴⁰ Children represent more than half of all Medicaid beneficiaries in this country. Although Medicaid is relatively generous in terms of eligibility for children (as compared with poor and low-income citizens in other age groups), benefits are constrained and vary greatly by state, and reimbursement is extremely low. In 1989 pediatricians received on average 57% of their usual fee for established patient visits and 70% of their usual fee for new patient visits from Medicaid.⁴¹ The program paid approximately 80% of Medicare rates and provided a reimbursement level slightly higher than the average overhead cost required to provide care.^{40,42}

Some of the economic inequalities among physicians are being addressed through the resource-based relative value scale (RBRVS) payment system. Because pediatrics is not a Medicare-utilized specialty, the RBRVS has had a minimal effect on pediatrician income. However, with the recent proliferation of the use of RBRVS-determined reimbursement by state Medicaid programs and private insurers, this situation is changing. The development of a comprehensive, pediatric-specific RBRVS would help to alleviate the disparity in income between pediatrics and other specialties, which in turn could affect the shortage and geographic maldistribution of pediatricians in the United States.

CONCLUSIONS

The absolute number of physicians caring for children is increasing, yet significant unmet health needs in the pediatric population exist. The majority of child health objectives established by the Surgeon General for the year 1990 were not achieved. With nearly 12 million children uninsured, and millions more underinsured, children's access to care is inadequate.

An increase in the number of pediatricians is necessary to meet the health needs of US children. This must be coupled with improved geographic distribution and an increase in representation of certain minority groups in pediatrics. Thus, the Academy supports the following recommendations for action.

Support the continued education and training of pediatricians.

- Encourage medical school admissions committees to select students with an interest in primary care.
- Support recruitment efforts to encourage medical students of the highest caliber to select pediatrics as a career.
- Advocate for adequate and realistic reimbursement for pediatric services to aid recruitment efforts.
- Support efforts to increase the enrollment of minority students in medical school.

- Encourage specific recruitment of underrepresented minority students into pediatrics.
- Insist on the inclusion of pediatrics and pediatric training programs in all primary care incentive programs at the local, state, and federal level. Ensure that policymakers recognize pediatrics as a primary care specialty.
- Support the restructuring of student loan repayment schedules so they are based on a percentage of earnings rather than fixed payments regardless of specialty choice.
- Support adequate and realistic reimbursement for pediatric services to help alleviate the disparity in income that exists between pediatrics and other specialty fields.
- Support changes in GME financing which favor the training of primary care physicians.

Seek the remediation of the undersupply of pediatricians in rural and inner-city areas.

- Support creative student loan forgiveness programs for physicians practicing in targeted, underserved areas.
- Support the expansion of the National Health Service Corps.
- Explore reimbursement differentials in Medicaid and other publicly financed care to pay higher rates for services delivered in identified underserved areas.
- Explore the creative use of tax credits and other means as financial incentives to physicians for providing care in identified underserved areas.

Support national workforce planning efforts.

- Continue to provide accurate, timely information to the COGME Physician Manpower Subcommittee, congressional subcommittees, and other governmental entities.
- Support the development of realistic, scientifically sound workforce models for both primary and subspecialty pediatric care.
- Continue monitoring of the pediatric workforce issue by following the significant changes occurring in the delivery and funding of health care.

COMMITTEE ON CAREERS AND OPPORTUNITIES, 1992 to 1993
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GRADUATE MEDICAL EDUCATION AND PEDIATRIC WORKFORCE ISSUES PRINCIPLES

The following draft principles were crafted by a special Task Force on GME convened by the American Academy of Pediatrics to develop policies and principles concerning GME and pediatric workforce issues. The Task Force met in the Washington office of the Academy on September 4, 1993. These principles have been reviewed at a meeting on September 9, 1993, revised and approved by the Federation of Pediatric Organizations. The Federation component organizations include: the Ambulatory Pediatric Association; American Academy of Pediatrics; American Board of Pediatrics; American Pediatric Society; Association of Medical School Pediatric Department Chairmen; Association of Pediatric Program Directors; and Society for Pediatric Research. These principles represent the consensus opinion of the American pediatric community comprising both academic and practicing physicians and residents.

OVERVIEW:

The United States is presently poised to enact a national health care insurance program that could include the coverage of an additional 12 million children and adolescents. The passage of such a proposal might eliminate financial barriers to needed health care for many children and generate an increase in demand for primary care physicians. These children and adolescents will need quality health care, the provision of which is very complex. Pediatricians are the most appropriate providers of primary care for infants, children and adolescents. Today, nearly two-thirds of office (physician) visits made by children aged 5 years and younger are to pediatricians.

There is presently a national shortage and geographic maldistribution of pediatricians the effects of which could be acutely aggravated by health care reform. The federated pediatric community agrees that there is a need for increased support for primary care specialties as a whole, and pediatrics in particular. In contrast to adult medicine and surgery, the overwhelming majority of pediatricians practice primary care medicine; less than 20 percent of certified pediatricians are certified in subspecialties and even fewer are practicing subspecialties exclusively. Currently, and for the past decade, over 60 percent of graduating pediatric residents still choose to enter primary care.

It is important to recognize the need for training of pediatric generalists and pediatric subspecialists to meet the unique clinical, research and educational needs of child and adolescent populations in the next century. There will be an increased demand for subspecialists (in the face of existing shortages) due to the complex illnesses faced by children and adolescents--congenital anomalies, pediatric AIDS, derivatives of substance abuse, etc. Some pediatric fellowship training --such as general academic pediatrics, adolescent medicine, behavioral pediatrics, developmental pediatrics --is often undertaken to enhance the pediatrician's ability to provide optimal primary care services and many graduates of such programs actually practice primary care.

Population and incidence of disease limit the numbers of pediatric subspecialty patients and, because of this, the number and distribution of subspecialists the country needs. There is currently an acute shortage of certain pediatric subspecialties (i.e., pediatric gastroenterologists, pediatric hematologist/oncologists and pediatric endocrinologists). In contrast to adult specialists, pediatric subspecialists are not usually found in private practice.

NATIONAL HEALTH CARE WORKFORCE COMMISSION:

The federated pediatric community recommends that an independent National Health Care Workforce Commission be established, insulated from the political process and with broad representation from the primary care community, including pediatrics. This National Health Care Workforce Commission would be responsible for:

- projecting the aggregate need of the medical care workforce for the health care delivery system;
- determining the necessary number of residency positions on a national basis (including the number of International Medical Graduates (IMGs)) and maintaining the appropriate number of generalists and subspecialists;
- allocating residency positions by specialty and subspecialty with regard to medical personnel and population needs;
- implementing appropriate incentives to reinforce the selection of primary care;
- conducting on-going research that will ensure the availability of appropriate data on which to base workforce decisions;
- evaluating and monitoring the efficacy of all recommendations and their implementation; ensuring that the process allows for flexibility, particularly during the transition period; and reevaluating recommendations as appropriate.

The federated pediatric community recommends that this independent and autonomous National Health Care Workforce Commission have features of both the Federal Reserve Board and the Defense Base Closure and Alignment Commission. The statute creating this National Workforce Commission would require that its recommendations be sent to the President for approval or disapproval, and then require the Congress to take an "up" or "down" vote on its package of recommendations without amendment. Its decisions, if accepted in this manner, are binding as statute.

The composition of the National Commission should be balanced and should reflect the entire primary care community as well as include representation from non-primary care disciplines. Its membership should include practicing physicians, medical

educators, allied health professionals, i.e., nurse practitioners and physicians assistants, hospital administrators and consumers.

The federated pediatric community believes that training and service needs should be disconnected. Therefore, distribution of residency training positions should be based on the quality of the training program. However, until there is appropriate distribution of training positions based on quality and primary care/specialty needs, we recognize that some service issues must still be considered.

The federated pediatric community believes that the ACGME and the RRC should maintain their current function and focus on quality, and should not be involved in the allocation of residency training positions.

ALLOCATION OF GME SLOTS:

The principal goal of the federated pediatric community is to increase the number of primary care pediatricians. We support the need to prepare more generalists. Accordingly, whatever mechanism for allocating residency positions is selected must assure that there are at least as many residency positions in pediatrics as currently exists. We recognize the need to decrease the total number of GME training slots overall, while simultaneously increasing the number of primary care slots. However, reliable data for projecting future physician need are not available, particularly the need for pediatric generalists and subspecialists.

While the goal of limiting the number of filled first year resident positions to 110 percent of the number of US medical school graduates may be a reasonable initial target, the federated pediatric community believes that the National Health Care Workforce Commission should ultimately establish the total number of residency positions, including IMGs.

The federated pediatric community supports the limitation of residency positions only if it is implemented subsequent to the allocation of slots across specialties and pursuant to the recommendations of the National Health Care Workforce Commission. The pediatric community is deeply concerned that, in some parts of the country, IMGs currently provide a significant portion of pediatric care especially in urban hospitals in under-served communities. In these communities, IMGs may provide more than 50 percent of care. The health of children in these communities must not be compromised by the reduction of residency positions while awaiting alternative health care providers.

The federated pediatric community believes the phasing in period, accompanied by transition funding, is vitally important to hospitals that lose a larger percentage of their residency positions through the allocation process or with the assignment of residents to ambulatory care sites.

PAYMENT FOR GME:

The federated pediatric community concurs with the Physician Payment Review Commission's (PPRC) 1993 Annual Report to Congress in its support of the concept that "all payers should share the costs of graduate medical education."

Within the limits of the national goals established by the National Commission, the pediatric community is in favor of maintaining as much flexibility of choice by resident applicants as possible. Operating under the allocation of residency slots established by the National Health Care Workforce Commission, the federated pediatric community supports a continuation of the current matching system.

One option to assist in assuring a distribution of residency specialties that will meet the future health needs of the nation is to explore the use of a voucher/certificate system given to medical students in conjunction with the National Resident Matching Program as suggested in a 1985 Report by the Task Force on Academic Health Centers of The Commonwealth Fund. Alternatively, funds could be allocated directly to programs or to regional or local consortia as proposed by the PPRC and the Council on Graduate Medical Education. Any one of these proposals would help assure that monies for medical education are used for that purpose.

Whatever the mechanism, it is preferable that the funds are allocated in a manner that facilitates the training of primary care physicians, including expanding the training venues outside of the hospital setting.

INCENTIVES, INCLUDING WEIGHTING OF PRIMARY CARE POSITIONS:

The federated pediatric community believes that primary care residents should receive total compensation that is equal to or greater than other residency positions in the institution.

The federated pediatric community believes that the use of differential weights in calculating payments for primary care residency positions could provide an incentive for teaching institutions to increase the number of primary care residency positions. However, these weights must be large enough to encourage the development of additional primary care positions and education sites outside of the teaching hospital. Funding must be specifically designated for this purpose.

This short term strategy must be accompanied by long term incentives for medical students, residents, and physicians (especially under-represented minority groups) to choose primary care. A full array of support for primary care should be considered including: expansion of the National Health Services Corp; continuation and expansion of primary care training programs, such as Title VII; loan forgiveness in return for practicing in identified under-served areas; loan repayment based on a percentage of

earnings; forbearance and deferment of low interest loans for entering primary care; development and implementation by all payers of a pediatric RBRVS and increased payment for pediatric services; increased funding for primary care research and other system-wide supports for pediatric and other primary care specialties including the reduction in administrative burden to primary care physicians.

RETRAINING:

Unlike adult medicine and surgery, retraining for pediatricians is not a significant issue because all pediatricians are initially trained as generalists and some take additional training in a subspecialty. Renewal of subspecialty certification in pediatrics also requires recertification in general pediatrics. However, the pediatric community strongly believes that the setting of standards for retraining other specialists in fields which include the care of children must involve the federated pediatric community. This is to ensure that the same quality of care is provided to all children and adolescents.

CONCLUSION

The Federation of Pediatric Organizations supports designing a program to ensure quality health care to all children by developing appropriate guidelines and funding for GME.

11/15/93

American Academy of Physician Assistants
January 25, 1994

**TESTIMONY ON WORKFORCE ISSUES
SUBCOMMITTEE ON HEALTH AND THE ENVIRONMENT
HOUSE ENERGY & COMMERCE COMMITTEE**

**submitted by
The American Academy of Physician Assistants
January 25, 1994**

Mr. Chairman and Members of the Subcommittee:

The American Academy of Physician Assistants (AAPA), on behalf of itself and the Association of Physician Assistant Programs (APAP), is pleased to present our views on the workforce issues contained within the Clinton health proposal that you are now considering.

AAPA and APAP

The AAPA represents the 23,500 actively practicing physician assistants (PAs) in the United States. PAs practice medicine with the supervision of licensed physicians. Approximately one-half of all PAs work in primary care, while 18 percent of all PAs are located in areas under 10,000 population. PAs are on the front lines of health care delivery at every level of our health care system. PAs work in hospitals, managed care settings and physician offices in addition to the military, VA and Indian Health Service systems. PAs are one of the principal components of the health care workforce providing medical care to Americans.

APAP represents the 58 programs currently approved by the AMA's Committee on Allied Health Education and Accreditation (CAHEA). These 58 programs graduate over 1,700 PAs each year.

Overview

Mr. Chairman, PAs will help us achieve the promise of universal coverage offered by the Clinton health reform proposal. The legislation you are now considering

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contributes to this goal, but can also be strengthened in several ways. Specifically, the legislation must:

- **Recognize PAs as an integral part of the services provided by physicians**
- **Assure an adequate supply of PAs for the future**
- **Promote effective utilization of PAs in all practice sites and settings by reducing obstacles to PA practice with physicians**
- **Increase use of PAs to improve access to care for such groups as the elderly and underserved, and**
- **Create an efficient and responsive bureaucratic structure to oversee implementation of current workforce policy and to develop new policy for the future.**

Summary of Recommendations

In this presentation we will make the following recommendations:

- **Retain recognition of PAs, now given in the proposed legislation, as a provider of physician services (Title I, Sec. 1112)**
- **Set aside a specific portion of the \$400 million in funding for "primary care physician and physician assistant training" specifically for PA education programs at a level higher than the current authorized level of \$9 million (Title III, Sec. 3071)**
- **Make PA education programs eligible for GME funds whether through the physician portion of GME or through a dedicated account for PA training (Title III, new section required)**

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- Assure that the expertise and experience developed by the PA profession in developing model state laws be included as part of HHS efforts in this area (Title III, Sec. 3071(e))
- Retain the provision extending Medicare coverage of PA services to all geographic areas (Title IV, Sec. 4022(a))
- Establish a uniform reimbursement rate for all PA services at 97 percent of the supervising physician's fee, and make this change effective for 1995 (Title IV, Sec. 4022 (a))
- Replace the proposed provision regarding funding for nursing under the National Health Service Corps program with language that would double the current 10 percent set-aside of scholarship and loan repayment awards for PAs, nurse practitioners and nurse midwives (Title III, Sec. 3472)
- Modify the recapture provisions related to the personal tax credit for primary care PAs practicing in Health Professional Shortage Areas who are unable to complete the 60-month mandatory service period (Title VII, Sec. 7801 and Sec. 23, Primary Health Services Providers)
- Extend the tax credit to PAs working in underserved areas prior to 1995 (Title VII, Sec. 7801 and Sec. 23, Primary Health Services Providers)
- Extend the tax credit beyond five years (Title VII, Sec. 7801 and Sec. 23, Primary Health Services Providers)
- Authorize Medicare bonus payments for PAs working in underserved areas (Title IV, Sec. 4115)
- Consolidate the functions of the councils and task forces created by the proposed legislation into one organization (Title III, Secs. 3001, 3062 and 3073)

The justification and explanation for these proposed changes follows.

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Recognition of services provided by PAs

The Clinton proposal places appropriate emphasis on the importance of workforce issues as part of its health reform proposal. If the goal of universal coverage is to be achieved, then national policy must focus on the production, organization and distribution of the services required to meet the expected demand for care.

Note, Mr. Chairman, that we use the term "services." We believe that the national debate on health workforce issues should focus first on the identification of the services to be considered as medically appropriate and necessary. Once these services are identified, attention should then be given to which health professionals are best able to supply the required services.

The proposal before you defines "health professional services" to include physicians and others legally authorized to provide physician services (Sec. 1112). The proposed legislation recognizes that PAs provide physician services of high quality that should be available to all Americans under health reform.

PAs are also included in the definition of "lawful health care provider," whose services must be covered under any fee-for-service plan offered by a regional alliance. Plans and alliances will negotiate reimbursement rates for PA services rendered to their patients.

Finally, PAs are specifically listed in the definition of health professionals who may be considered "essential community providers" eligible for certification. Thus, PAs will be a part of service delivery systems that will address directly the needs of underserved populations.

PAs work as part of a team with physicians and other health care providers to provide care across a broad spectrum of practice areas and sites.

The recognition of PAs as a core component of the team approach to health care delivery should be retained in health reform legislation.

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We do not recommend that the legislation mandate the use of PAs or any other willing provider. The definition of health professional services as currently written will assure that medical services are provided by qualified individuals, such as PAs.

Future supply of PAs

PAs represent a flexible and cost-effective way of supplying the services necessary to meet the demand for care likely to result from health reform. To assure an adequate supply of PAs, the provisions of the legislation relating to support for PA educational programs must be strengthened.

The core of all PA training programs is preparation for work in primary care. PAs receive much the same basic science and clinical preparation as physicians as is provided during the second and third years of medical school. All PA education programs must meet CAHEA approved criteria, which helps to assure not only the quality but also the homogeneity of PA training. In addition, all PAs must take a recertification examination every six years to maintain their national certification. The core of this test is primary care. No other health profession requires all of its members to be recertified in this fashion. No other health profession gives the emphasis to primary care that the PA profession does.

Historically, a large number of PAs have chosen to work in primary care. Currently, forty-eight percent of all PAs work in family practice, pediatrics, internal medicine or obstetrics and gynecology. If emergency medicine is included (PAs often provide the non-emergent care delivered through an emergency clinic), the proportion of PAs in primary care increases to fifty-seven percent.

But PAs are also very adaptable by virtue of their training. Increasingly, PAs are being used in specialty care. What is attractive about PAs to specialists is the PAs' understanding of medicine, their ability to enhance the primary care component of a specialist's practice, and their ability to learn quickly the in-depth knowledge and skills associated with specialty practice based on their training and individual competence.

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PAs thus represent a useful and adaptable resource for the health care system.

It is also cost-effective to produce a PA. While it has been estimated that a PA can provide a significant fraction of a physician's services (some estimates are 80 percent or more), the cost of educating a PA is only about one-fourth that of educating a physician. Because PA training is only two years in length compared to four years plus residency for a physician, the supply of PAs can be increased quickly.

Despite the obvious value of PAs to the health care system and the cost-effectiveness of their training, only \$6.5 million was spent last year through Title VII in support of PA education. This funding contributed to the production of 1,710 graduates last year. This total represents an increase over the amount appropriated each year for the previous ten years (\$4.9 million). The \$6.5 million for the current fiscal year also can be compared to the \$16.9 million spent last year to support the production of approximately 1,500 nurse practitioners and nurse midwives.

The proposed legislation authorizes spending \$400 million to cover "primary care physician and physician assistant training," plus programs for the training of underrepresented minorities and nurses.

We would request that a specific portion of these funds be set aside for PA education programs at a level higher than the authorized level of \$9 million.

Core support for PA programs, however, should come from a stable source that will not be subject to the vicissitudes of the appropriations process each year. The proposed legislation changes the financing of graduate medical education. Rather than coming entirely from the Medicare trust fund, physician residency training would also be supported by money set aside from private health insurance premiums collected by corporate and regional alliances. In a precedent-setting move, the bill allots \$200 million of these funds for graduate nurse education.

Given that PAs are trained to provide many of the services now offered by physicians, and that PAs represent a flexible and valuable resource as the health care marketplace responds to the challenge of health reform,

we would request that PA education programs also be eligible for GME funds either through the physician portion of GME or through a dedicate account for PA training.

Utilization of PAs

As already noted, the proposed legislation recognizes that PAs are essential to the delivery of health care under health reform. The bill includes language encouraging and supporting full utilization of the "professional education and clinical skills of advanced practice nurses and physician assistants."

A distinguishing feature of the practice of PAs is the *team approach* to health care. The team approach emphasizes the importance of coordination and communication among health care providers. It is not enough merely to "treat and refer." Patients are greatly disadvantaged by a fragmented system of care in which providers work independently and shuttle patients to and from separate sources of care for individual problems. Patients should have one source of care for the majority of their health care needs. And the providers offering this care should be able to communicate easily and quickly with one another. This is the model of PAs and supervising physicians.

PAs practice medicine with a significant degree of autonomy yet still with the supervision of licensed physicians. Patients who are treated by a PA receive a wide range of services for a variety of different conditions. PAs not only treat patients but educate them as well. This role is essential to PA practice, and patients appreciate the time spent with them in this function. More importantly, PAs know and their patients know that PAs are part of a network of care. Consultation with a physician is as available as a phone call or a knock on the door of a nearby office.

Despite the strength of this practice, important obstacles remain to the full and complete utilization of PAs in a team approach to care remain. Specific obstacles would include:

- lack of prescriptive authority for PAs in some states

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- overly restrictive supervisory requirements for PAs in some states, and
- lack of recognition by some third party reimbursers.

The proposed legislation authorizes the Department of Health and Human Services to encourage the adoption of model professional practice statutes for PAs, and to remove inappropriate obstacles to the effective use of PA practice.

We support this provision, but would request that additional language be included to direct the Secretary of HHS to consult with appropriate professional societies on the development of a model law so that the expertise and experience developed by the PA profession can be utilized on this project.

Access to care

Medicare

At the present time, there is no standardized basis for coverage of PA services to Medicare patients. Services are reimbursed at varying rates in different locations, and there is no coverage at all in certain locations.

Since 1985, a number of bills have been introduced in both the House and the Senate to standardize Medicare coverage for services provided by PAs in all practice settings at a uniform payment rate. HR 3600 amends existing law and extends Medicare coverage for outpatient physician services provided by PAs from rural Health Professional Shortage Areas (HPSAs) to all geographic areas. Reimbursement would be paid to the PA's employer at 85 percent of the physician's fee.

We support the provision extending PA services to all geographic areas.

However, reimbursement for PA services still varies considerably in other ways depending on whether the PA provides care in a skilled nursing facility or intermediate care facility, practices in a hospital (other than assisting at surgery), or

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assists in surgery. This inhibits the otherwise appropriate and cost-effective use of PAs.

We would recommend that:

- a uniform reimbursement rate be set for all services
- the uniform rate be set at 97% of the physician's fee, and
- these changes be made effective in 1995.

The net effect of these changes would be to eliminate inequities in the reimbursement of PA services and to provide a positive incentive for the expanded use of PAs in the Medicare program. Expanded use of PAs, particularly in rural and inner city areas, would promote greater access to care for the elderly populations residing in these areas.

National Health Service Corps

The proposed legislation increases funding for the National Health Service Corps scholarship and loan repayment programs. These increases would be very beneficial because there are presently far more applicants than can be accommodated through the current program. PAs have been very successful in competing for this financial aid, and have been a mainstay of health care for many communities participating in the program.

In addition to increasing funding levels, however, the bill requires that 20 percent of all NHSC participants be nurses. This change fails to recognize or give weight to the significant role that PAs have played in the NHSC in providing care to underserved areas.

We would recommend that the bill's provisions with respect to nursing be replaced with language that would increase the current 10 percent set-aside of scholarship funds to 20 percent for scholarships and loan repayments for PAs, nurse practitioners and nurse midwives.

Tax incentives

The legislation also contains a \$500 per month personal tax credit for primary care PAs practicing full-time in Health Professional Shortage Areas. This can be an

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important incentive to attract more providers to underserved areas. To provide as great an incentive as possible for practitioners not only to go to shortage areas but to remain there as well, we would recommend the following:

- **Modification of the recapture provisions for PAs unable to complete the 60-month mandatory service period**
- **Extension of this credit to PAs working in underserved areas prior to 1995 (to help retain PAs in these areas)**
- **Extension of the tax credit beyond five years (also to retain PAs in these areas)**

Bonus payments

In addition, we recommend that:

- **Medicare bonus payments, currently available only to physicians, be authorized for PAs working in underserved areas**

Tax incentives are an inducement to relocate to shortage areas, but Medicare bonus payments help retain providers in these areas. They provide some small financial adjustments to help cover the cost of delivering care to underserved elderly patients.

Bureaucratic structure to implement workforce provisions

The proposed legislation would establish a National Council on Graduate Medical Education, a National Council on Graduate Nurse Education, and a National Institute for Health Care Workforce Development. Potentially, the creation of these three institutions could create confusion in terms of lines of authority and responsibility for workforce issues.

We recommend that Congress consider consolidating the functions of these three offices into one council or agency. We further recommend

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that all affected professions be represented on this council or agency together with consumers and payers.

Conclusion

Mr. Chairman and members of the subcommittee, we believe that a national health care program should provide basic health care services to all residents. Further, we believe that the scope of such services should be determined by public policy and be based on considerations such as medical effectiveness. Health services should be provided by qualified persons who practice in a team approach to care. Patients should retain a choice of providers and be satisfied with the quality of care offered by the providers and the health care system. Finally, we believe that the structure of a national health care program should be determined by Congress and administered by the states under national guidelines. We will support financing mechanisms that are fair, equitable, and include cost controls. We look forward to working with you in the further development of legislative proposals directed at these ends.

**TESTIMONY OF THE
AMERICAN OCCUPATIONAL THERAPY ASSOCIATION**

Chairman Waxman, Representative Bliley and Members of the Subcommittee:

The American Occupational Therapy Association, Inc. (AOTA) appreciates the opportunity to submit testimony to the Subcommittee on Health and the Environment to share our views on proposed changes to the health care delivery system under President Clinton's reform plan.

The Association established in 1917, represents the professionals interests of 48,000 occupational therapists, occupational therapy assistants and students of occupational therapy. As health and rehabilitation professionals, our members provide services to people of all ages disabled by illness, injury, psychological congenital or developmental impairment. The goal of occupational therapy is to enable individuals to achieve a maximum level of independent functioning in their everyday lives. Occupational therapy services include, but are not limited to, providing for the development, improvement or restoration of sensori-motor, oral motor, perceptual or neuromuscular functioning or emotional, motivational, cognitive or psychosocial components of performance; and interventions directed toward developing, improving, or restoring daily living skills, work readiness or work performance skills. These services may require assessment of the need for, design of, and training in the use of assistive technology.

Occupational therapy practitioners provide services to millions of people each year in acute care and rehabilitation hospitals, nursing facilities, freestanding clinics, psychiatric facilities, school systems, homes, offices of independent practitioners and other community settings.

The President's health care reform initiative presents the opportunity to reform our health care system in a comprehensive manner to improve the availability of health care to all Americans. It challenges us to create a system of care with participation by all health care providers to ensure access to quality care while encouraging cost containment and real competition. Comprehensive reform can enable us to examine health care with a wide lens, encompassing a view of health which addresses the needs of an individual to lead a full and productive life. It offers the opportunity to solidify gains made possible by new knowledge in areas such as assistive technology, and to refine and redirect trends such as managed care to better meet the health care needs of Americans.

However, a comprehensive revamping of the health financing and delivery system brings with it potential for unintended consequences and adverse effect. Our testimony targets initiatives envisioned in President Clinton's plan that we believe will create barriers to appropriate care and serve to undermine a comprehensive system of care that accurately reflects actual care provided and needed, particularly for more vulnerable underserved populations.

The Association believes revising our health care delivery system to ensure consumer health care needs are met requires:

- designing managed care systems with adequate safeguards that allow access to necessary care when deemed appropriate by qualified gatekeepers, through a range of accessible practice settings;
- ensuring an adequate health workforce, particularly for underserved populations, by allowing all health professionals access to graduate medical education, Medicare shortage area bonus payments, and opportunities related to essential community providers and manpower shortage areas under the Public Health Service Act;
- guaranteeing a level playing field for all health care professionals by requiring health plans to include all types, classes and categories of health care professionals as qualified providers, and eliminating other existing barriers to practice.

ACCESS TO QUALITY CARE IN MANAGED CARE PRACTICES

President Clinton's cost containment initiatives raise real concerns about the prospect of underservice, particularly as it relates to specialized non-physician services that are dependent on gatekeeper or primary care provider referral. Under the President's proposed cost containment strategies, health plans are likely to be compelled toward stricter payment and service volume controls. Under such a scenario all consumers will be at risk, but individuals with chronic conditions or disabilities will be particularly vulnerable. Experience within the current managed care environment, where examples of financial incentives to restrict access and questionable quality are too common, are not encouraging. Strong quality assurance mechanisms, developed with participation by a full range of health professionals, as well as strong grievance procedures, is critical to ensuring quality care while attempting to contain health care costs.

The Association has endorsed the managed care safeguards articulated by the Consortium for Citizens with Disabilities (CCD) Health Task Force, a copy of which is attached for the Subcommittee's review. Specifically, these recommendations address problems such as financial incentives used to restrict access, the lack of an array of comprehensive services needed particularly by children and adults with disabilities, the lack of adequate quality assurance mechanisms and effective grievance policies to ensure access to appropriate care; and the lack of expertise and training on the part of gatekeepers to determine the needs of individuals, particularly the specialized needs of individuals with disabilities, and access to specialists and specialty care.

The gatekeeping function is of particular concern when determining the rehabilitation needs of an individual. Creating a gatekeeping process that can ensure individuals have

access to appropriate care, whether it be rehabilitative or other specialty care, must recognize a single gatekeeper's limited expertise in these specialty areas. Managed care plans should not be permitted to arbitrarily select one health discipline to be the gatekeeper for all individuals, and in effect, control and possibly limit the range of services available. Information on the health needs of the individual, as well as information on current and appropriate practices, must be sought from a variety of sources, including the health professional whose service is under review. A multidisciplinary team approach can be required where a combination of opinions are solicited, including the opinion of a specialist licensed and trained specifically to provide the service being evaluated.

ENSURING AN APPROPRIATE RANGE OF PRACTICE SETTINGS

Under a revised health reform plan, consumers should have access to a full range of practice settings from hospital-based care to community-based settings and offices of private practitioners. The President's plan does not require alliances or health plans to ensure consumer access to services in a full range of practice settings. In fact, all health plans that are not fee-for-service plans, would be exempt from state laws prohibiting a single source supplier for services. This has serious implications for ensuring accessibility to needed care, particularly for consumers in rural and underserved areas. We urge the Subcommittee to examine this issue closely as it proceeds.

ENSURING AN ADEQUATE HEALTH WORKFORCE

The appropriate shift envisioned under health care reform to primary, preventive and rehabilitative care requires an examination of the supply of both physicians and non-physician health professionals to ensure access to a comprehensive range of care. Physicians do not provide all of the nation's health care. We believe it is important to recognize the manpower shortages exist across all health care professionals. Opportunities to participate in education and training programs should be available to all health care professions proportionate to their manpower shortages. Additionally, the same incentives, such as loan forgiveness and bonus payment programs, should be offered to non-physician health professionals to encourage them to work in underserved areas and with underserved populations. These health professions also must have access to the same opportunities to increase enrollments of students from culturally diverse backgrounds.

The President's plan is unbalanced in its support for funding of a broad range of health professional education programs needed to serve these shortage areas. Health care reform efforts should focus on providing access for consumers to high quality health practitioners by supporting activities which would provide greater numbers of these professionals.

The President's plan lacks the clarity necessary to ensure that a broad range of essential providers will be available to serve vulnerable populations in both rural and inner city areas. Health care reform must recognize that there is a wide array of health professionals critically important to our nation's ability to meet the health care needs of millions of Americans. Particular types of providers are essential to certain specialty populations. Rehabilitation services are critical to enabling an individual to achieve a maximum level of independent functioning, and are often the vital link to an individual's ability to lead a full and productive life.

The Association believes that compelling evidence exists documenting a serious and continuing shortage of occupational therapy practitioners throughout the country. Based on the Association's own research, we estimate there is at least a 25% shortage of occupational therapists nationwide. The shortage of occupational therapy assistants is even higher. Although the current supply of occupational therapists and occupational therapy assistants is at an all time high (46,357 occupational therapists, 12,000 occupational therapy assistants) the demand for occupational therapy services far outstrips the supply of trained professionals.

Several factors have contributed to the need for additional occupational therapy services. The aging of our nation's population has placed additional strains on the health care system. Technological advances have allowed injured and disabled individuals to survive conditions that in the past would have proven fatal. A recognition of rights of the disabled population has also increased the demand for rehabilitation care. Finally, increasing numbers of occupational therapists are moving into nontraditional practice settings, including private practice.

Ample evidence from independent sources corroborate the Association's contention of widespread personnel shortages. Included among them:

- The American Hospital Association reports vacancy rates at 3,100 hospitals for full time occupational therapists in 1991 at 14.2 percent nationwide - the second highest health professional vacancy rate reported. This percent is up from 13.6 percent reported by the AHA in 1989.
- The U.S. Department of Health and Human Services' annual Report to the President and Congress on the Status of Health Personnel in the United States has consistently noted that critical personnel shortages within a number of health professions is a growing problem, and has identified occupational therapy as one of those professions.
- In a landmark study of allied health professions, the National Academy of Sciences' Institute of Medicine expressed serious concern over the supply of occupational therapists and future demand.

The U.S. Bureau of Labor Statistics projects the field of occupational therapy among the twenty top growth professions for the 1990s. Of the five fastest growing health professions, occupational therapists rank number four and occupational therapy assistants rank number five. The supply of occupational therapists is expected to increase by 55 percent from 1990 through 2005, or a need for 20,000 additional therapists. Demand for occupational therapy assistants will grow by 5,000 or 57 percent during the same period (*Monthly Labor Review*, U.S. Bureau of Labor Statistics).

Despite the severe overall shortage of occupational therapists (the overall ratio of occupational therapists to the population is 12.6 per 100,000) the shortage is even worse in some rural areas and in particular states. States with especially low ratios of occupational therapists to state population include West Virginia (3.8 per 100,000), Mississippi (3.9), Kentucky (6.8), South Carolina (6.6), Tennessee (5.7), Nevada (7.4), Georgia (7.7), Idaho (7.2), Utah (6.0), Oklahoma (7.3), Puerto Rico (2.5), and the Virgin Islands (2.0). Occupational therapy assistants are relatively scarce in Idaho, Utah, Nebraska, southern states, the Appalachian region and Puerto Rico.

Other evidence for the severity of the shortages is the fact that new graduates of educational programs for occupational therapists and occupational therapy assistants are receiving between 3 and 4 job offers each. Most find jobs within a month of graduation and sometimes accept scholarships from employers in exchange for employment agreements upon graduation.

Lastly, the shortage is severe enough that employers are increasingly looking overseas for therapists to fill positions in the United States. Evidence comes from the numbers of foreign-trained occupational therapists who are applying to take the national certification examination offered by the American Occupational Therapy Certification Board (AOTCB), which is used as a qualification standard by most of the 49 States which license or otherwise regulate the profession. The number of approved foreign applicants for the examination increased from 185 in 1986 to 509 in 1992. Actual applicants approved for 1993 totaled over 900.

The enrollment of students from ethnically diverse backgrounds in occupational therapy education programs is also low. Only 9.8% of the students enrolled in programs to train occupational therapists and 15.3% enrolled in programs to train occupational therapy assistants are from ethnically diverse backgrounds.

GUARANTEEING A LEVEL PLAYING FIELD FOR ALL HEALTH CARE PROFESSIONALS

Assuring appropriate access to necessary health care services and making our system more cost-efficient will require broad provider participation in the health plans among which consumers will choose. The President's health care reform proposal does not require any health plan to include any particular type of health professional. In earlier

drafts of the President's proposal, explanatory language was included which indicated that health plans were expected to have a sufficient mix of providers and specialties to assure adequate access by consumers. The Association was concerned at that time that an "expectation" was insufficient to assure the desired outcome. Barriers continue to exist in the health care marketplace that prevent non-physician health professionals from practicing within the scope of their professionally recognized education and training. Now the final version of the President's plan has even eliminated any reference to an "expectation." In fact, the legislation exempts health plans from many state laws, including state freedom-of-choice laws.

Legislation must ensure that non-physician health professionals have equal opportunity to participate along with physicians and hospitals in forming health plans and that non-physician health professionals are proportionately represented in health plans. Limited fee-for-service plans and HMO point-of-service options with higher premiums and additional copays do not go far enough to offer a level playing field for all qualified health care professionals.

Barriers to practice are always anticompetitive because they restrict the ability of a group of health professionals to compete in offering and providing services to consumers. A variety of restrictions exist in both current federal and state law and practices. Privately imposed barriers to practice may be violations of the antitrust laws, as well, especially if they are imposed by competitors of restricted or excluded health professional groups. Examples of barriers experienced by occupational therapists and other non-physician health professionals include:

- supervision by physician requirements and physician referral rather than direct access to a non-physician professional;
- denial of clinical/hospital privileges and criteria for participation in a health plan tied to hospital privilege requirements;
- subjective or arbitrary insurance reimbursement policies, such as denial of a reimbursement for services performed within the scope of any licensed provider's practice if there is coverage of the service provided by the physician;
- inability to obtain malpractice insurance for anticompetitive reasons not related to competence;
- limitations on scope of practice more restrictive than justified by skill, education and clinical training as stated by the profession;

- joint state licensing board jurisdiction over certain non-physician health professionals by the state medicine board as well as the licensing board of the particular profession;
- limitations in the use of billing codes that reflect the scope of services furnished by non-physician providers; and
- exclusion from participation on managed care panels, and limited referrals when on panels.

Health care reform provides the opportunity to remove such barriers, while achieving other important reform goals of access and choice.

The Association is concerned that state licensure, certification and registration requirements and national certification standards and practice guidelines as recognized by the various professional organizations continue to be respected under health care reform. The President's proposal would override restrictive state practice laws: "No state may, through licensure or otherwise, restrict the practice of any class of health professionals beyond what is justified by the skills and training of such professionals." We applaud the President's effort to eliminate barriers, but we are troubled that this language, as written, may give states the right to weaken the use of state credentialing requirements as the criteria used to ensure that services are provided by qualified professionals.

Additionally, the President's proposal discusses the use of "national standards" in various sections of the health care plan when discussing services, practice guidelines and health care professionals. Any national certification standards should reflect existing education and clinical training programs, as well as the accreditation requirements, certification standards and practice guidelines recognized by each professional association. We believe the health care plan should clarify the importance of referring to these standards for each health profession when identifying the appropriate national standards that should be used.

We urge the Subcommittee to incorporate provisions into health care reform legislation that would prohibit purchasing cooperatives and health plans from denying any type, class or category of health care professional who provides covered services from participating as a qualified provider. Additionally, it is important that reform legislation recognize non-physician health professional qualifications under state licensure, certification and registration laws and guarantee that these professionals can perform patient care activities within their professionally recognized scope of practice.

In addition, national health care reform should ensure an appropriate and sufficient representation of all health professionals, including occupational therapists, on the national, regional, and state health boards, including similar representation and

participation in the Quality Management Program data collection system envisioned under the plan. Non-physician health professionals should participate in the development of practice guidelines and the clinical effectiveness of services of these professionals should be studied.

ANTITRUST EXEMPTIONS

The Association is concerned with the antitrust exemptions in the President's plan. We believe that such exemptions will further exacerbate inherent disparity in bargaining power, resulting in continuous and increasing control by hospitals and physicians. Among other exemptions, the President's plan would allow alliances to negotiate with providers before setting fee schedules, and allow providers to collectively negotiate.

The President's plan also proposes that guidelines would be developed by the Department of Justice and the Federal Trade Commission to assist health care providers determine whether their activity might subject them to antitrust enforcement. On September 15, 1993 The Department and the Commission issued a first set of guidelines entitled, "*Statements of Antitrust Enforcement in the Health Care Area*". The guidelines, as presently written, apply only to physicians and hospitals. Although the FTC has given us assurances that non-physician health professionals would be evaluated by the same standards as physicians, there needs to be additional formal clarification as to whether the guidelines apply equally to all health professionals. The guidelines also fail to address whether exclusion of competitors would be considered a potential violation.

AOTA believes that all health care professionals should have equal bargaining power with health plans. Health care reform legislation should create an environment of good faith bargaining where monopolistic practices, competitor collusion or discrimination by physicians, hospitals and health plans toward non-physician health professionals will not be tolerated.

The Association appreciates the opportunity to submit this testimony, and we look forward to working with members of the Subcommittee as the health care reform debate moves forward.

TESTIMONY OF CORNELIUS J. PINGS, PH.D.
PRESIDENT, ASSOCIATION OF AMERICAN UNIVERSITIES

Mr. Chairman and members of this Committee, I appreciate the opportunity to share with you the interests and concerns of universities regarding health care reform, particularly universities with academic health centers. The Association of American Universities (AAU) represents the nation's leading public and private research universities. This statement and the positions noted are fully supported by the National Association of State Universities and Land-Grant Colleges (NASULGC) and its President Peter Magrath. Together, with some overlap in membership, we represent the sizable majority of institutions with academic health centers.

The AAU and NASULGC have established a Task Force on Health Care Reform comprised of university presidents and chancellors, as well as medical school deans and vice presidents of academic health centers. Two senior university financial officers also serve on the task force. The task force is examining the key issues of interest to universities in health care reform in order to inform our membership and serve as a resource to the university community, as well as to the Administration and the Congress. The issues the task force are concentrating on include universities as providers of health care, as educators of health care professionals, and as employers, as well as the role of university-based biomedical research in health care reform.

Under the Clinton plan, universities, like all employers, will be required to pay 80 percent of health care premiums and cover part-time as well as full-time employees. In addition to the other employer mandates required by the Clinton plan, universities will need to make certain decisions similar to other large employers. For example, many private universities have 5,000 or more employees and could qualify for corporate alliance status. Private universities and colleges will need to consider the pros and cons of becoming a corporate alliance or joining a regional alliance. State universities and colleges will need to adapt university policies and procedures to comply with regional alliance decisions made by the states and localities.

To some extent, individual universities may find that the Clinton plan affects some elements of current practice on campus. For example, some of our institutions offer retiree health benefits, while others do not. In still other instances, decisions will be made for us. If the Clinton plan is adopted in its present form, Medicare coverage will be extended to all state and local government employees, including employees of state colleges and universities. At the present time, coverage of state and local government workers is limited to employees hired on or after April 1, 1986, and to state employees hired before that date pursuant to an agreement with the Secretary of the Department of Health and Human Services.

All of these choices and changes will affect university resources and, in many cases, significant changes will be required in the content and manner in which health care benefits and services are provided and paid for.

Of great interest to us under the Clinton plan and any other plan to reform

the health care system is the recognition of the essential role played by academic health centers and the importance of providing sufficient resources to support the multiple missions of these centers. While the Clinton plan does identify academic health centers as integral to our health care system, we want to ensure that the funds essential to fulfilling the multiple missions of academic health centers are provided. Academic health centers educate health professionals, conduct world-class research, and provide care to many people, including a significant portion of those who now are uninsured and cannot afford to pay for services. At many academic health centers, a significant portion of the care provided is uncompensated. While the AAU and NASULGC appreciate the call for universal coverage, we know this guarantee of coverage will require a carefully considered transition period which does not pull the financial rug out from under the centers that will continue to be relied upon to provide health care services to many people, with or without a health security card, in both the short-term and the long-term. We urge you and the Subcommittee to pay particular attention to the support that will be needed for academic health centers in any new health care system, particularly during the transition period from the current system to a new one.

The restructuring of our health care system will have a significant impact on the many teaching hospitals, such as the hospital at UCLA and Harbor General, that have traditionally served as the sites for care delivery, clinical research, and the education of health professionals in primary, secondary and tertiary care services. Before coming to the AAU, Mr. Chairman, I was the Provost at the University of Southern California for 12 years. As you know, the teaching hospital associated with the USC health center is Los Angeles County Hospital, one of the largest and busiest public hospitals in the country. Health care reform proposals to change the various funding streams that have been supporting the county's efforts to maintain this hospital will not only affect those who rely on Los Angeles County Hospital for services, but it will also affect the providers and the county budget as well. There are clearly many reasons to reform a health care system that is overwhelming facilities like the Los Angeles County Hospital with increasing demand and decreasing resources. But as we reform our system, I urge a careful assessment of how each aspect of the proposals considered by Congress will affect the ability of academic health centers to continue to provide care, conduct research, and educate health care professionals.

Let me turn for a minute to the issue of educating health professionals, a topic that has received a good deal of attention in the health care debate. The Clinton plan calls for at least 55 percent of all medical residents to be enrolled in generalist training programs by the year 2002. As I understand it, generalists would include family medicine, internal medicine, pediatrics and OB/GYN. Your bill, H.R. 2804, The Primary Care Workforce Act of 1993, calls for a 50-percent ratio, with mechanisms built in for determining the need for and allocation of residency positions over time. Mr. Chairman, we recognize that there is clearly a demand and need for more primary care providers in a new system that will rely heavily on primary care and prevention services.

However, I raise three issues for your consideration in this area. First, whatever the final decision about primary vs. specialty residency training programs, the physicians of tomorrow will need to be educated in our medical schools. Some of the education process may be provided in the community, outside the medical school and the teaching hospital, but medical schools will and should continue to be the focus for quality medical education, whether a student is planning to be a primary care provider or a specialist. Any changes in the funding level and mechanism for graduate medical education should be carefully considered for the impact such changes may have on academic health centers and schools of medicine.

Second, universities and academic health centers around the country all have different histories, different cultures, and frankly, different strengths. I hope any proposal to increase the number of primary care providers will recognize and affirm the diversity of our institutions while we strive to meet certain national health care provider goals.

Finally, it is increasingly important that we look to many other health care professionals to serve as primary care providers in a reformed health care system. Nurses, dentists, physician assistants, to name just a few, will be needed to provide services, and sufficient resources will be needed to support education programs for these providers. While the Clinton plan authorizes additional dollars for these programs, most of the money will need to be appropriated from an already severely constrained discretionary budget. We could well find ourselves in a situation where we have created a system that relies on additional primary care providers (doctors and other professionals) before we actually have the providers in place to provide the services. It will take time for the 55/45 or 50/50 mix of generalists and specialists to be realized and, without sufficient resources, we will be unable to educate the other health professionals the system will need to succeed.

Another area of concern to many universities is the role of biomedical research in health care reform and, indeed, the impact of reform on our current investment in research. Of particular concern is the future of clinical research conducted at academic health centers around the country. As I indicated earlier, academic health centers have funded their various missions through multiple financing streams. Many of these financing streams have supported aspects of clinical care and research that are not covered by a research grant or other outside source. As we move toward a system that changes the way we finance graduate medical education, and the ways we finance clinical care and reimburse for services under Medicare and Medicaid, I urge that you remain diligent in preserving the kind of core support that enables academic health centers to conduct the research essential to the development of new and more cost-effective therapies and treatments.

I also urge that, in the debate on health care reform, we remember the importance of our current investment in biomedical research through the National Institutes of Health (NIH). The Clinton plan calls for increases in the

investment in research, specifically in prevention and health services research. We fully support these proposals and are appreciative of their inclusion in the Clinton Plan. However, as you know, these increases are not paid for under the Clinton plan. The funds for this research will have to be appropriated out of the discretionary budget, the same budget that funds our current investment in research as well as many other vital domestic programs. Again, we urge your careful attention in this area to ensure that we do not shift the funding from one vital area of research to pay for another.

Even as we speak, market forces are at work which are driving our institutions to make changes, many of them long overdue. University presidents and chancellors across the country are taking a critical look at their institutions and thinking strategically about how to maintain quality programs with fewer dollars. Many universities, particularly those in your home state and mine, are already experiencing the impact of the explosion of managed care programs and have begun to make institutional changes and adjustments.

Mr. Chairman, historically, universities have been problem solvers. We have taken on complex and difficult problems and tried to find solutions. Health care reform poses a significant challenge for the nation and for the university community. Changes are already occurring and clearly more are on the way. Many of these changes will not be easy, but the university community wants very much to work with you and with the President to make the kinds of changes that address the significant weaknesses in our current health care system while we preserve and support some of our greatest strengths. My colleagues and I look forward to working with you as you address the challenges ahead.

STATEMENT OF PROFESSOR CHRISTOPHER T. WALSH
President, Dana-Farber Cancer Institute

submitted on behalf of

M.D. ANDERSON CANCER CENTER, Houston, TX
CITY OF HOPE NATIONAL MEDICAL CENTER, Duarte, CA
DANA-FARBER CANCER INSTITUTE, Boston, MA
FOX CHASE CANCER CENTER, Philadelphia, PA
FRED HUTCHINSON CANCER RESEARCH CENTER, Seattle, WA
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MEMORIAL SLOAN-KETTERING CANCER CENTER, New York NY
KENNETH NORRIS JR. CANCER HOSPITAL, Los Angeles, CA
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to the
Subcommittee on Health and the Environment
Committee on Energy and Commerce
U.S. House of Representatives
January 25, 1994

ASSURING CANCER PATIENTS ACCESS TO APPROPRIATE CARE
IN THE HEALTH SECURITY ACT

The National Cancer Program was enacted by Congress in 1971 to improve the prevention, diagnosis, and treatment of cancer. An important element of the program is the designation by the National Cancer Institute (NCI) of comprehensive and clinical cancer centers.

The NCI-designated cancer centers are the cornerstones for deepening the understanding of the causes and cures for cancer, for applying this knowledge to patients under treatment, and for disseminating this knowledge to community hospitals. The cancer centers have developed many of the major advances in cancer treatment.

The role of these national resources -- and the continued success of the National Cancer Program -- may be threatened by health care reform unless their special mission is taken into account:

- The definition of an academic health center should include a cancer hospital that is excluded from the Medicare Prospective Payment System. The President's proposed definition of an academic health center does not include cancer hospitals that are excluded from the Medicare Prospective Payment System.
- Patients in managed care programs must be guaranteed access to the NCI-designated cancer centers.

Cancer patients must be permitted to choose treatment at an NCI-designated cancer center without extra financial charge.

Otherwise the cancer centers could be available only to affluent patients.

In addition, NCI-designated cancer centers should be automatically treated as designated specialty providers to which managed care plans must allow the referral of their enrollees.

- The basic benefits package must cover treatment of cancer patients in qualified clinical trials that substitutes for standard, and possibly less effective, therapy.

The customary exclusion of "investigational" services must not extend to qualified clinical trials involving cancer patients, since the reasons for the exclusion do not apply to such trials.

- Any rate-setting methodology must be designed to accommodate the atypical services and patients of these cancer centers.

These NCI-designated freestanding cancer centers treat a disproportionate number of severely ill patients and use particularly sophisticated techniques. Current law affords nine freestanding cancer centers special status under the Medicare reimbursement system because of their atypical services and patients. Comparable status for both in patient and outpatient services should be afforded the nine centers under any payment mechanisms adopted by states or health alliances.

The Cancer Centers Are National Resources

As part of the National Cancer Program, the NCI was directed to designate certain cancer centers to develop new treatments for cancer and introduce them into clinical practice.¹ These state-of-the-art therapies and research activities offer the greatest possibility for successful treatment of cancer patients. Moreover, research is the driving force that allows these cancer centers to develop new innovations that replace less effective cancer treatments and provide a positive impact on both the quality of life for cancer patients and the cost of treatment.

As the centers develop new methods for treating, preventing, and detecting cancer, they demonstrate their effectiveness through treatment of patients at the centers and disseminate information on these developments so that they can be incorporated into clinical practice throughout the country. Much of the progress made in understanding the biology of cancer and the treatment of this disease is directly attributable to the work done in these NCI-designated cancer centers.

These cancer centers have played pivotal roles in developing and advancing treatments for childhood leukemias which previously were often fatal

¹ 42 U.S.C. §§ 285a through 285a-3.

and are now highly curable; safely substituting lumpectomy for mastectomy in many breast cancer patients; developing techniques for the early detection of cancer; originating limb preservation techniques that minimize disability and disfigurement; developing bone marrow transplantation to cure previously untreatable cancers; and perfecting ambulatory cancer treatment for large numbers of patients. The work continues, as the cancer centers innovate in such areas as gene therapy and immunotherapy. The cancer centers' endeavors have contributed to the increasing number of survivable cancers and have enabled countless individuals to return to productive lives.

Health care reform must be undertaken in a manner that does not undermine the National Cancer Program nor deprive patients access to these cancer centers.

Assuring Access Under Managed Competition

Many health care reform proposals, including the President's, are intended to foster the development of managed care. In any expansion of managed care, extreme care must be taken to assure that cancer patients are not denied the state-of-the-art treatment available primarily, and often only, at the NCI-designated cancer centers. These federally designated national resources must continue to be available to the general population and should not be limited to affluent patients who can afford high coinsurance payments or special insurance coverage.

Moreover, without a patient base with which to test promising new techniques, the essential translation of treatment advances from laboratory bench to the patient's bedside will not occur. Without patients, the cancer centers would be unable to carry out their mission under the National Cancer Program.

Therefore, any health care reform legislation must contain the following protections to assure access by cancer patients to the NCI-designated cancer centers --

- Any cancer patient enrolled in a managed care plan would be guaranteed the right to choose treatment at an NCI-designated cancer center. Managed care plans would be required to arrange for such treatment at the same cost to the patient as for in-network services.
- Managed care plans would be required to provide information on NCI-designated cancer centers to plan enrollees.

In addition, the President's proposal should be modified as follows --

- Health plans should be required to permit the referral of their patients to designated specialty providers and centers of excellence. This should be a state mandate -- not a state option, as the President's plan would apparently provide.
- NCI-designated cancer centers should automatically be considered to be designated specialty providers or centers of excellence.

- Although the regional health alliances would be organized on a state basis, access to NCI-designated cancer centers should not be limited to in-state centers. Health plans should be required to permit the referral of their patients to an NCI-designated cancer center that can provide appropriate services regardless of location.

The Basic Benefits Package Should Cover Qualified Clinical Trials

A clinical trial on a new cancer therapy is initiated because of the belief, based on preliminary evidence, that the therapy is likely to be more effective than the conventional therapy otherwise available. The trial is intended to establish the superiority of the new therapy definitively. Patients in trials benefit since they receive treatment that may be substantially better than conventional treatment and that, in any event, is not likely to be less effective.

The NCI-designated cancer centers plan a major role in conducting clinical trials of new methods to prevent and treat cancer. Through such trials, the cancer centers develop the standard of treatment that are eventually used by physicians and institutions throughout the country. The system of NCI-designated cancer centers is a model structure for determining which treatments are effective

Although clinical trials offer the possibility of superior treatment for cancer patients, insurers frequently deny coverage of the associated medical care, such as the hospital stay or physician visits, under policy or plan provisions excluding "investigational" or "experimental" treatment. By inappropriately invoking provisions designed to prevent payment for questionable or speculative treatments, insurers have adopted policies precluding reimbursement for state-of-the-art, advanced medical treatments that are frequently more effective, and ultimately most cost effective, than those the insurers would readily pay for.

The National Cancer Institute agrees that health insurance should cover clinical trials --

"NCI does not consider the research exclusion justifiable. For patients with life-threatening diseases for which standard therapy is inadequate or lacking altogether, participation in well-designed, closely monitored clinical trials represents best medical care for the patient. The NCI believes that clinical trials are standard therapy for cancer patients to whom a curative therapy cannot be offered.... For these reasons, we consider it appropriate for third-party carriers to reimburse patients for medical care costs of participating in scientifically valid clinical trials."

* Raub, William F. "Remedies and Costs of Difficulties Hampering Clinical Research." January 1989. (Submitted to the Senate Committee on Appropriations in response to S. Rep. No. 100-399.)

The basic benefits package established in health care reform legislation must include coverage of the medical care associated with clinical trials provided to cancer patients if the trials have been approved by (1) NCI or an NCI-designates cancer center, cooperative group, or community clinical oncology program; (2) the Food and Drug Administration, in the form of an investigational new drug exemption (IND); (3) the Department of Veterans Affairs; or (4) a qualified nongovernmental research entity as identified in the guidelines for NCI cancer center support grants.

Coverage of cancer clinical trials should not increase aggregate health care costs. Treatment of cancer patients through clinical trials is ordinarily a substitute therapy that is not necessarily more expensive than conventional therapy.

The President's proposal would include the "routine costs" of approved clinical trials in the guaranteed national benefits package. The scope of routine costs is unclear at this time. While we would not expect administrative costs of the clinical trials to be covered, all patient care costs should be covered.

The Nine Freestanding Cancer Centers Should Be Protected From Inappropriate Rate-setting Payment Methodologies

Although most of the NCI-designated cancer centers are part of larger, diversified institutions, nine of them are renowned, freestanding facilities.³ As such, they are particularly vulnerable to any health care financing measures that do not take their unique characteristics into account. For that reason, Congress determined that the Medicare Diagnosis-related group (DRG) system was inappropriate for the nine centers.

By law, Medicare exempts the nine centers from the prospective payment system (PPS) for inpatient hospital services and instead pays them under a cost-reimbursement method.⁴ Since PPS uses DRGs based on typical cases, Congress concluded that it would not be appropriate for the atypical services of, and patients treated by, the nine cancer centers.

In a June 1993 report, the Prospective Payment Assessment Commission (ProPAC) reconfirmed that the reasons for the statutory exemption continue to

³ The nine are: M.D. Anderson Cancer Center, Houston; City of Hope National Medical Center, Duarte, California; Dana-Farber Cancer Institute, Boston, Massachusetts; Fox Chase Cancer Center, Philadelphia, Pennsylvania; Fred Hutchinson Cancer Research Center, Seattle, Washington; Arthur G. James Cancer Hospital and Research Institute, Columbus, Ohio; Memorial Sloan-Kettering Cancer Center, New York, New York; Kenneth Norris Jr. Cancer Hospital, Los Angeles, California; Roswell Park Cancer Institute, Buffalo, New York.

⁴ 42 U.S.C. § 1395ww(d)(1)(B)(v).

exist today.⁶ The statutory exemption acknowledges the cancer centers' status as unique, state-of-the-art facilities with the most acutely ill cancer patient populations. Importantly, the exemption confirms that the existing cancer DRGs do not reflect the complexity of illnesses treated at the cancer centers, or the intensity of services provided.

If health care reform legislation allows or requires rate-setting, it should include special requirements governing the nine freestanding cancer centers comparable to the Medicare exemption. For example, under the President's proposal, the regional alliances would issue fee schedules for the fee-for-service health plans, and states could regulate payments under health plans to assist the health alliances in meeting the federally required premium targets.

As Congress recognized in exempting the nine freestanding centers from the Medicare prospective payment system, controls based on average cases or the experience of ordinary institutions, such as controls based on DRGs, would be completely inappropriate for these freestanding centers. Federal legislation should require a similar approach, with respect to both inpatient and outpatient services, for any rate-setting by states or regional alliances.

An appropriate rate-setting methodology would be based on the historical costs (e.g., average-per-patient costs) of each freestanding cancer center, updated to reflect inflation and any significant changes in the center's patient case-mix or services provided. Any such methodology should be subject to revision based on changes at each center. Rates must be established in a manner such as this if the nine freestanding cancer centers are to remain viable.

Alternative State Systems

Some proposed health care reform plans would allow states to substitute their own reform and cost control plans for the national program. If this is permitted, the federal legislation should require states to adopt the protections and benefits package requirements specified above. The National Cancer Program is an important federal initiative that should not be thwarted by state regulation that does not adequately accommodate the NCI-designated cancer centers.

Summary

To ensure that the services of the NCI-designated cancer centers remain available to patients, and that these centers continue to provide complex, state-of-the-art treatment, it is essential that health care reform be structured to include the following elements:

- The definition of an academic health center should include cancer hospitals that are excluded from the Medicare Prospective Payment System.

⁶ Prospective Payment Assessment Commission. "Medicare and the American Health Care System" Report to the Congress." June 1993. Pages 84-85.

- Patients in managed care plans suffering from cancer must be guaranteed access to the specialty services and treatment available at the NCI-designated cancer centers without the financial penalties assigned to out-of-network care.
- All managed care plans should be required to provide information on NCI-designated cancer centers, and how to access their services, to their enrollees.
- In the President's plan, NCI-designated cancer centers, including out-of-state centers, should be included as "designated specialty providers" to which health plans must allow the referral of their enrollees.
- Qualified clinical trials must be included in the basic benefits package.
- Rate-setting applicable to the nine freestanding cancer centers should be limited to an appropriate non-DRG rate-setting methodology for both inpatient and outpatient services.
- Any alternative state systems created under the health care reform legislation should be required to include comparable protections for the cancer centers and patients.

Statement
of the
Group Health Association of America

GHAA appreciates the opportunity to submit testimony on Health Care Reform and Essential Community Providers. The Association represents 350 health maintenance organizations with 33 million members who account for about 75 percent of total HMO enrollment.

HMOs provide integrated, coordinated, high quality health care at predictable cost to consumers who consistently give HMOs positive reviews, which are reflected in high enrollment renewal rates. The HMO Act of 1973 was predicated on the belief that HMOs represent a logical way to integrate the financing and delivery of health care. That belief has been borne out, and the benefits of HMOs membership are especially valuable to medically underserved populations.

In the course of this testimony we will discuss these major points:

- (1) the valuable health care delivery resources represented by community based providers and HMOs serving medically underserved areas;
- (2) opposition to requiring HMOs to contract with essential community providers, a term that is broadly defined in the Clinton health care reform plan (GHAA has similar concerns about any other provisions that might require HMOs to contract with specified providers, such as academic health centers);
- (3) support for provisions of the Administration's health care reform proposal that would assist community health centers and other community based providers to develop the expertise and systems to contract successfully with managed care organizations;
- (4) strong support for affording Medicaid beneficiaries the same range of choices available to the non-Medicaid population, including the opportunity to choose a

managed care plan or to choose to receive services from a community based provider on a fee-for-service basis without enrolling in a managed care plan; and

- (5) our interest in working with the Congress, community health centers and other community based providers to develop alternatives to the required contracting provision that will retain the availability of community based health care resources under health care reform.

HMOs enroll members from medically underserved populations in a variety of urban and rural areas across the country, and GHAA member plans that have become established in medically underserved areas are deeply involved in these communities. Some of these member plans have developed successful relationships with other community based providers, and several have sprung from established community health centers.

As a consequence, GHAA has a keen appreciation of the vital role played by community health centers and other community based providers, and strongly supports preservation of community based health care resources under health care reform. GHAA member plans in medically underserved areas share many of the concerns of these providers about ensuring that the needs of the populations they serve are met under health care reform.

HMOs serving these diverse high risk populations have developed an array of successful programs to reach out to increase accessibility of health care services and to encourage improved care-seeking behaviors. These programs include systems to provide transportation to and from appointments, staff with linguistic skills and cultural sensitivity to communicate effectively with members, incentive and outreach programs to

encourage prenatal and well-baby/well-child visits, clinical staff trained to anticipate and overcome environmental obstacles to successful treatment, and cooperative arrangements with school-based clinics and hospital emergency rooms to encourage use of HMO primary care providers.

An example of the success that can be achieved by HMOs serving high-risk populations was cited recently Jay Harrington, President and Chief Executive Officer, Neighborhood Health Plan, an HMO formed by the community health centers in Massachusetts. A four year old boy was hospitalized for injuries sustained in a fall from an open window. In the course of his treatment he was transferred from a community hospital to a medical center hospital for orthopedic surgery. The medical center was one and a half hours by public transportation from the family home, and the boy's mother could visit him only every two to three days. The orthopedic surgeon recommended continuation of care at the medical center beyond the boy's need for acute care, because he was concerned about the adequacy of physical therapy in the weeks following the surgery. By arranging twice-daily physical therapy at home, skilled nursing home visits twice weekly, and weekly paid transportation to the medical center for examination, Neighborhood Health Plan satisfied the surgeon that the discharge was appropriate. The boy was reunited with his family 10 days after the original injury and had a successful recuperation. In addition to benefiting the child, NHP's coordination of his care resulted in a significant cost savings in contrast to longer term

hospitalization.

Many other such examples exist of the coordination by HMOs of care for vulnerable populations that enhances quality, is sensitive to the special needs of these enrollees and is also cost effective. Among them are:

- The Wellness Plan in Detroit that has achieved a significant reduction in maternal prenatal complications, a decline in the number of low birthweight babies and a decline in infant morbidity and mortality through special programs for the low-income members who constitute the majority of its enrollment;
- United Health Plan/Watts Health Foundation in Los Angeles that originated as a community health center and offers a wide range of services, including health education programs on AIDS and other sexually transmitted diseases, smoking and family planning, a 24-hour health information service ("Health Talk") and 5 Mobile Medical Centers; and
- the Chinese Community Health Plan in San Francisco that offers bilingual and other special services, such as culturally appropriate health promotion and disease prevention programs, for the Chinese community it serves.

In light of commitments such as these by HMOs to meeting the needs of medically underserved populations, GHAA recognizes the important role played community based providers that focus predominantly on providing health care services in medically underserved areas and emphasize special services and strategies

to reach these populations. We are supportive of efforts to develop health care reform proposals that preserve the community based resources that in many, if not most, underserved areas been the primary source of health care for a very long time.

However, we believe that the provisions in the Administration's proposal that require health plans to contract with "essential community providers" are counterproductive. Under the Administration's proposal, "essential community providers" means:

migrant health centers,
community health centers,
homeless program providers,
public housing providers,
family planning clinics,
Indian health programs,
AIDS providers under the Ryan White Act,
maternal and child health providers,
federally qualified health centers and rural health clinics,
providers of school health services,
community health networks,
and
additional providers meeting standards in the proposal and other standards to be developed by the Secretary, Department of Health and Human Services, including such providers as public hospitals and other institutional care providers and health professionals practicing in health professional shortage areas or providing a substantial amount of health services to medically underserved populations.

Our member plans have demonstrated that the comprehensive coordination of inpatient and outpatient services, primary and specialty care, and essential enabling services that HMOs can offer to these populations also represents an important resource. Requiring contracting with broadly defined "essential community providers" strikes at the heart of HMO organizational principles and will undercut the availability of HMOs and other managed care

organizations to medically underserved populations.

At the heart of HMO operations and structure and crucial to their ability to provide to all of their enrollees health care that is high quality, accessible and cost effective is their ability to select providers who practice best within an organized system, meet HMO criteria for quality and cost effectiveness and are necessary to meet the needs of their enrolled membership. Medically underserved populations will benefit most if relationships between community based providers and HMOs and other managed care plans are based upon a sound understanding of the characteristics and resources represented on both sides and negotiation occurs that is responsive to the needs of all parties.

We are supportive of the assistance that the Administration's proposal offers to community based providers to develop the expertise and resources they need to successfully contract as partners with managed care organizations. GHAA strongly believes that alternatives must be explored to give Medicaid beneficiaries and other medically underserved populations a choice of health plans. One possibility that is consistent with GHAA's strong position in support of health plan choice for all consumers that includes managed care and fee-for-service options would be to permit Medicaid beneficiaries and other low-income populations to select community based providers on a basis similar to the fee-for-service option that is available to employed populations. We recognize that there are

serious funding considerations in determining how to address financial barriers to insure continued accessibility of services under such an option, however choice of health plan is a critical principle that should be as important for the underserved as for the employed.

In conclusion, we believe that successful relationships between HMOs and community based providers can be expanded, and we are engaged in efforts to make this a reality. The most successful relationships will be mutually beneficial partnerships based on a clear understanding of the benefits to enrollees that can be achieved. We look forward to working with the Congress, community health centers and other community based providers to develop alternatives that will provide an opportunity for medically underserved populations to continue to select these providers and will ensure the continued availability of the enabling services that are critical to making health care accessible to these populations.

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**STATEMENT OF
THE NATIONAL ASSOCIATION OF COMMUNITY HEALTH CENTERS
HEARINGS ON HEALTH CARE REFORM
AND THE MEDICALLY UNDERSERVED**

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE, the National Association of Community Health Centers (NACHC) is the national membership organization of over 700 community, migrant and homeless health centers providing comprehensive primary care services to over 7 million underserved Americans in 1400 sites across the country.

NACHC and its member health centers are well aware of the failures of our health care system, in particular because we care for millions of Americans who have been forgotten or left behind – unserved, or poorly served at best – by the existing health care system. In this context, health centers strongly support the President's call for meaningful health care reform to provide universal coverage to all Americans that can't be taken away, improve access to care – especially to preventive and primary care, and contain health care costs.

The needs of the underserved in health care reform are clear, and attainable this session of Congress:

- The underserved need a place to go for entry into the health system -- a medical "home" that responds to their unique needs, that is geographically and physically accessible, culturally and linguistically competent, and available during evening and weekend periods; and that offers comprehensive primary care and "enabling" services, like transportation, translation and outreach. Universal coverage, though essential, is not enough, as access to health insurance does not necessarily mean access to health services;
- The underserved need an adequate supply of physicians and health professionals who are trained to understand and respond to their unique needs and health care problems; and --
- They need the assurance of knowing that the essential community providers which have historically served them will be able to continue doing so, through initiatives that provide adequate reimbursement (taking into account the inherently higher costs of caring for them) and risk contracting safeguards designed to protect their fiscal solvency.

We want to work with the President and Congress to capitalize on this golden opportunity -- let's make health care reform work for all Americans. Clearly, we now

have the best opportunity in over half a century to extend access to affordable, quality health care to every American. The President's leadership will be essential in seeing the legislation through to final enactment. As presented, the President's plan makes several vital contributions toward improving access to health care and ensuring health security by:

- extending comprehensive coverage to millions of people who are currently uninsured or inadequately insured, with benefits equal to or better than those offered by many of the largest companies;
- eliminating current industry practices of denying or discontinuing private insurance coverage because of previous or current health conditions, or due to a change or loss of job;
- proposing to substantially reorient our health care system -- including the training of physicians and other providers -- to focus more on low-cost, high-payoff preventive and primary care, including coverage of important preventive services;
- proposing to expand and improve preventive and primary health services in underserved rural and inner-city areas;
- recognizing and safeguarding the key role of health centers and other "essential community providers" in caring for low income and underserved communities.

With the inclusion of these elements, President Clinton's proposal lays a solid foundation for achieving effective national health reform, and for ensuring that every American -- no matter what their circumstances -- has access to affordable, quality health care.

As much as NACHC and its member health centers support the President in his efforts to place health reform and universal coverage at the top of the nation's agenda, we must note that several elements found in the Health Security Act raise serious concerns about how well or poorly the reformed health system will serve the unique needs of America's underserved. In particular, the Health Security Act relies heavily on a system of managed competition, under which several health plans -- most of the managed care type -- will compete for Health Alliance enrollees, ostensibly on the basis of price and quality of care. This focus on managed competition could work to assure care and at the same time contain costs for most Americans. Yet while managed care has been cited frequently for its successes in effectively organizing available local health resources to improve access to health care while at the same time holding down the cost of care, there is no evidence that the presence of managed care in a community has successfully increased the level of available resources there, a critical factor in improving the health of underserved communities.

Moreover, managed care entities and HMOs have historically avoided the underserved

because of their unique needs and inherently higher costs. A market-based, competitive health system with a foundation in managed care, as envisioned in the Health Security Act, means that in the end costs will overwhelm all other considerations. The most expensive patients in the health system -- the underserved and those in greatest need of health care -- will likely encounter significant discrimination and barriers to obtaining health care services. For some areas and populations -- in particular low income, rural and inner-city minorities, and other at-risk Americans -- this approach may not improve access to care, and could even prove detrimental.

This fear is further heightened by the limited nature of proposed federal cost-sharing assistance for low income persons and families. Under the President's bill, federal subsidies would cover some or all of the employee share (20 percent) of the weighted-average premium for employed individuals with incomes below 150 percent of the federal poverty level; however, the subsidy will not cover premium charges by plans that exceed the weighted-average premium. This limitation could effectively restrict the choice of poor persons to only low cost plans, thus running the risk of creating a de facto two-tier system. Similarly, federal subsidies for deductibles and co-payments will be available only for deductible and co-payment amounts that exceed the "low cost sharing" levels; thus, even the poorest Americans will face some cost sharing, including \$10 per doctor visit and \$5 per prescription. While few would argue with the principle of encouraging personal responsibility, this burden will have its most telling effect on pregnant and postpartum women, infants, and those with chronic or complicated illnesses, because they will need frequent care and multiple medications.

Some of the many potentially serious problems that could be faced by low income Americans and the working poor in a managed competition-based system include -

- Severely Restricted Choice of Plans or Providers: Because of the restricted subsidies, individuals with family incomes below 150% of the Federal poverty level are unlikely to be able to afford the premium surcharges for higher-cost plans. By this standard, 60 million people -- 25% of the entire population -- will be able to choose only among the lowest-cost plans, and will be subject to the discrimination and poor quality often associated with the Medicaid program. It is unclear whether or to what extent low-income and other medically vulnerable populations will be assisted to enroll in plans, select a plan that works best for them, and to obtain the care and services they need, which in many cases go beyond the care and services included in the required package and furnished by traditional plans.
- Lack of Plan Capacity: Those who can afford only a basic plan may find there are not enough such plans available with enough capacity. Few plans will be willing to market coverage at the premium charged by basic plans, and will instead target employer-insured families.

- Increased Discrimination and 'Redlining': Due especially to the inadequate financing, health plans will have every incentive to avoid areas with high numbers of low-income people. Fly-by-night plans will be the only providers bidding for coverage in these low income-areas -- resulting in diminished access and lower quality services for all enrollees there. Depending on how Alliance and plan service areas are delineated major redlining could occur, with low-income, racial and ethnic minorities, and at-risk populations gerrymandered into segregated Alliance and plan service areas and subject to less oversight and poor quality care. The experience with redlining under Federal voting rights and credit lending laws suggests that no duty not to redline can counteract wide discretion in drawing identifiable service areas.
- Obstacles to Specialty Care: Lower-cost plans are more likely to require stricter utilization review and place more obstacles between low-income patients and specialty care. In particular, persons with chronic illnesses or disabilities may be adversely affected if plans are permitted to severely restrict out-of-plan referrals or payment for specialized care and services. Also, plans will presumably be required to cover out-of-area services (at least for emergency/ urgent care needs). However, it is not clear yet how this will work under the President's plan. This is a critically important issue for migrant farm workers, transportation employees and others whose work requires frequent and extensive travel, and involves multiple employers.
- Inadequate Monitoring of Quality and Access: Based on the experience with Medicaid, states and Alliances may not be able to adequately monitor quality and access in low-cost plans, especially when faced with the pressing need to hold down the cost of care.

Simply put, underserved Americans are in the health care predicament they are in because they have been rejected by the private market. Thus, if market forces work for health care like they have worked in other sectors of the economy, underserved people and communities run the risk of being red-lined, short-changed and, in the end, getting far less care than they need or deserve.

In addition, the Clinton plan places heavy reliance on states to administer the new program, and states are given considerable flexibility in doing so, or in opting out to run their own independent program. Unchecked state flexibility could mean a substantially diminished role for Federal laws and programs for disadvantaged and underserved Americans that were crafted to respond to the inability or unwillingness of states to address these problems in the past. The current Medicaid program provides an instructive example of what can happen if consistent federal rules are lacking or are not fully enforced; and the plans recently put forth by states such as Oregon and Tennessee underscore the potential dangers for disadvantaged, minority, and underserved people that could accompany the lack of consistent national standards under health reform.

Finally, undocumented persons will be barred from public subsidies and from receiving employer-subsidized benefits (thus disqualifying millions from the employer coverage they now have). All hospitals presumably would still be required to furnish emergency care to undocumented persons under Federal anti-dumping law, but potentially hundreds of millions -- if not billions -- of dollars in uncompensated care would remain, with as yet no clearly identified Federal funding to cover the cost.

These concerns underscore the critical need for a substantial, Federally-administered "safety net" for millions of disadvantaged and underserved Americans, even after reform is implemented. The Health Security Act acknowledges this principle, but its response falls critically short on several counts. For example:

- **Access to Care:** the Health Security Act's Access Initiative calls for an investment of about \$1 billion in the expansion of primary care services in underserved areas, in assisting in the formation of service delivery networks, and in furnishing key 'enabling services,' such as transportation and translation services, to those living there. However, this new investment would be offset by reductions in funding for existing programs -- beginning with \$180 million in 1996 and rising to \$650 million by 1998, including \$300 million from the health center programs and millions more from the Family Planning, Maternal and Child Health Block Grant and Ryan White AIDS programs -- thus reducing the *net* new investment to less than \$400 million, or about \$10 for every underserved American, at its highest point.

Nearly all of the funds would be administered under a *totally new, discretionary program*, which would target its resources to a wide variety of organizations, including for-profit HMOs, private doctors and private health plans, with little or no community involvement or accountability; resources would not be targeted to underserved communities directly.

Further, the discretionary construct of this new program raises the distinct possibility that existing programs, such as the health centers, Family Planning, MCH, and Ryan White, which will continue to fill vitally important purposes even after reform is implemented, will be pitted against the new program for scarce federal resources -- even after the Act's proposed offsets take effect. Senators Fritz Hollings and Tom Harkin have fought harder than almost any other Member of this institution for funding for these programs, yet have been unable to keep their funding on par with general inflation, much less health inflation. A discretionary funding construct for a health reform access initiative -- with creation of a totally new, duplicative program notwithstanding -- essentially assures that funding levels for these programs will never be adequate.

Members of this august Committee must consider: if this program is enacted in its current form, who will be around to pick up the pieces when this well-intentioned, but incredibly naive and ill-informed policy fails?

- **Essential Community Providers:** The Health Security Act recognizes those who currently care for the underserved (such as community, migrant and homeless health centers, family planning clinics, and Maternal and Child Health clinics) as "essential community providers" (ECPs), and extends certain rights, such as contracting and payment requirements, for the first five years after reform begins.

All Health Plans are **required** to contract with ECPs in their service area. ECPs that elect to contract on an "in-plan" basis (most health centers are likely to do this) will be paid no less than other providers for the same services by the Plan. **This does not account for the inherently higher costs of treating high volumes of underserved, at-risk patients.**

ECPs that contract on an "out-of-plan" basis (most likely, school-based clinics, health care for the homeless, etc.) will be paid based on the Alliance-developed fee schedule or the most closely applicable Medicare methodology (for a health center, FQHC cost-based reimbursement), at the ECP's choice. The problem here is that **patients who go to an "out-of-plan" provider are subjected to a minimum 20% cost sharing requirement – pricing many low-income, disadvantaged patients out of this option altogether, and therefore making it effectively infeasible for an ECP to choose.**

ECPs also get precious few safeguards from risk-based contracting by health plans. A likely scenario under the Health Security Act: the health plan gives the mandatory contract to the ECP, but on a risk basis; the health plan assigns the ECP the sickest patients, and pays the ECP no less -- but no more -- than other providers for the same services, with the ECP at risk for any costs in excess of the health plan's capitated payment. The ECP is out of business in 2-3 years.

NACHC feels one overriding policy should govern the construct of an Essential Community Provider initiative: those providing comprehensive primary care services in underserved areas should be paid an adequate rate, and should be exposed to minimal risk. A goal of the Health Security Act is for more caregivers to provide primary care, especially where it is most needed, and for more of the underserved to receive primary care and preventive services. Unfortunately, the current structure of the Essential Community Provider provisions of the Act basically guarantee that that goal will go unmet.

- **Health Professions Education and Placement:** Under the Health Security Act, the nation's medical schools and teaching hospitals -- which have played no small role in the current oversupply of specialists and our critical shortage of primary care physicians -- would continue to be the principal beneficiaries of a \$6 billion entitlement in the President's plan, an "additional payment" for the specialized care they provide, as well as the lion's share of a separate \$6 billion pot to fund Graduate Medical Education costs.

Community health centers with teaching programs have produced hundreds of family physicians, general internists and general pediatricians – exactly the kinds of doctors our health system desperately needs – yet they get nothing in the way of funding to continue or expand their educational efforts in the President's plan. Currently health centers with teaching programs are required to affiliate with a sponsoring medical school or teaching hospital. Payment for the costs of the health center's educational program is made on a "pass-through" basis with the sponsoring institution. The result is that many "teaching health centers" end up eating a substantial portion of the costs of their educational efforts. Further, the availability of residency opportunities in community and migrant health centers is directly linked to the availability of teaching hospitals willing to engage in educational partnerships with them.

We'd like to have direct access to medical education funds so we can provide practice opportunities for medical residents and expose more medical students to the benefits of providing primary care in an underserved area. The available literature shows that where medical residents are exposed to primary care training in a community-based setting, significant numbers enter primary care as a practice. For the health system envisioned under the Health Security Act to function, it will have to generate significant numbers of new primary care physicians. Community and migrant health centers anxiously await the opportunity to participate in those physicians' education.

Making Health Reform Work for Underserved Americans

We believe that, if health reform is to work for underserved communities, it must empower medically underserved communities to develop workable, permanent, responsive community health care systems, through steps to:

- provide a substantial investment of guaranteed resources to develop community-based health care networks and health plans, and to continue and increase support for key programs that now provide vital services to disadvantaged and underserved populations (including the health center programs, Family Planning, and others);
- strengthened safeguards for Essential Community Providers that assure preservation of the existing safety net in underserved communities, and their full participation in the new health care system;
- assure the participation of ECPs in health professions education and training and provide for payment to cover the cost of their involvement, to guarantee adequate supply of primary care educational opportunities for medical students in the most appropriate settings.

The most pressing need of -- and the most rational response to -- the medically underserved under any health care reform approach is increased availability of community-responsive, comprehensive primary health care services, particularly under a market-driven approach to reform where the bottom line will take absolute precedence. Yet more can and should be done than just investing in service development: the lesson of the health center programs is that, although it may not be possible to empower communities to take control of the entire new health system, it is possible to empower them to own and operate their own entry points into it. Even with their great successes, however, health centers are currently able to reach only 15% of the 43 million medically underserved Americans who need access to community-based primary care services. Health centers were founded with a vision of community and consumer empowerment, and their experience over the past 30 years provides an object lesson on how consumer involvement and community empowerment can succeed where other models have failed. In this sense, health centers may be the last, best hope for communities in shaping their health care system and making it responsive to their needs. For obvious reasons, we strongly believe that any access initiative worthy of the name should retain and significantly expand upon the health center model because:

- o it is a proven model of getting Federal funds to improve the health of hard-to-reach populations to the areas that need them most;
- o health centers represent a multibillion dollar investment by the Federal government in primary care infrastructure in underserved communities over the last 30 years, and are the only entities that have attracted and retained health professionals in shortage areas;
- o health centers have proven their effectiveness, cost efficiency and quality of care over the past 30 years;
- o it is a proven model of empowering underserved communities to control their own points of access into the health system, and to tailor the services provided by the center to the unique needs of the community;
- o the centers' consumer governing boards are accountable for efficient utilization of Federal funds and quality of services provided, and health centers are subject to strict monitoring and oversight by Federal agencies, unparalleled in the private sector.

Policymakers should look hard at what has worked and why, and what has not worked for the underserved:

- o Who has provided culturally competent care and ACCESS to these communities? Who has not?

- o Who have seen all regardless of the ability to pay? Who has not?
- o Who has kept costs in check while developing innovative approaches to meeting the health needs of these communities? Who has not?
- o Who has attracted, trained and kept physicians and qualified health professionals in underserved communities? Who has not?
- o Who has genuinely empowered communities to develop long-range solutions to their health care needs? Who has not?

Thus, we firmly believe that health reform should build on what has worked, by calling for a substantial new investment in health centers --

- o as the President's original plan proposed;
- o as last year's Democratic Senate Leadership Bill proposed;
- o as the House and Senate Republican Health Reform bills propose;
- o as the single-payer bill (S. 491/H.R. 1200) proposes.

We are asking the President not to compromise on his pledge to make ACCESS as important as cost containment, and to make health reform work for the current system's outcasts. Build health empowerment systems with a new investment in the Community Health Center program to meet the needs of all underserved communities.

Members of Congress can and must make sure that health care reform "stays on track" and works for our Communities. Congress knows what works and should renew its commitment to Community Health Care. This is not about a program, but rather an approach to empower communities to develop and direct long range solutions that will work for them.

In summary:

- President Clinton made a commitment to equality of access to health care. We fully support that pledge, and believe that health care reform should work for all Americans, and especially for the medically underserved.
- There is much to admire and support in the President's proposed plan; at the same time, some elements cause considerable concern about how well the plan will address the most pressing needs of underserved Americans.
- Health care costs will never be controlled unless high-risk, underserved populations have access to primary and preventive care. Access to health insurance does not necessarily mean access to health services.
- Health care reform should build on what has worked: the community, migrant and homeless health center programs. Nothing else has our uniquely successful, 30-year track record of controlling costs, providing access to quality care, retaining health professionals where they're most needed, or empowering communities to develop long-range solutions to their health needs. Health reform should invest in such successes.
- We are committed to support and work with the President and the Congress to ensure the earliest possible passage and enactment of an effective, comprehensive national health reform plan.

Thank you.



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